Med Trib 1

Medical Tribune and Medical News

© 1976, Medical Tribune, Inc.

Vol. 17, No. 1 — *world news of medicine and its practice—fast, accurate, complete* — Wednesday, January 7, 1976

Medical Tribune's Editorial Credo

In the beginning of the 1970's, MEDICAL TRIBUNE *stated its editorial credo for the decade ahead. With minor modifications it is even more pertinent today than it was then:*

MEDICAL TRIBUNE began its life in the United States in 1960 . . . It seems appropriate to reaffirm its credo and . . . reorder its editorial priorities in the light of past events and future needs.

In our view, the clear and present needs of medicine can best be served, not only for physicians and scientists but also for patients and the general public, by working toward specific goals in the following order of priority.

We must act at the highest levels to:

1. Preserve freedom of scientific inquiry.
2. Preserve freedom of responsible medical practice.
3. Increase the number of physicians, nurses, and technicians and obtain more and better medical care and research facilities.

We must address clinically and from a public health perspective

4. Alcoholism, drug addiction, and other psychic disorders.
5. Malnutrition and obesity and disease-related factors.
6. Hypertension, coronary artery disease, and atherosclerosis.
7. Maternal health and child care.
8. Environmental pollution.
9. Cigarettes and cancer.
10. Auto safety and accidents.

To these priorities we pledge the unceasing dedication of MEDICAL TRIBUNE.

Editorial

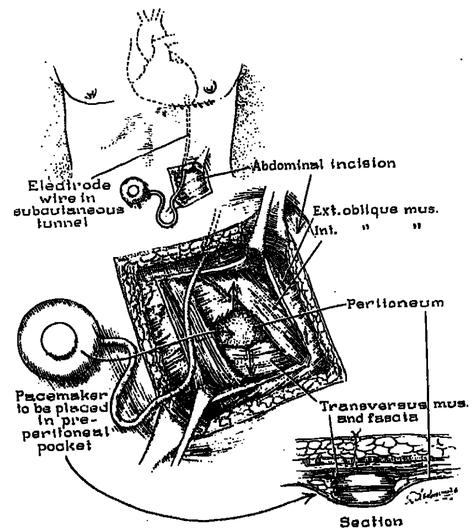
To Preserve the Progress of Science

MEDICAL TRIBUNE, for more than a decade, has warned and fought against growing government bureaucratic impingements upon scientific freedom. Preservation of the freedom of responsible scientists and physicians has been part of the credo to which MEDICAL TRIBUNE has been dedicated since its founding.

Now, in a period of two months *Science*, editorially aroused by what has become "a clear and present danger," has returned repeatedly to the issue of the freedom of American science, which rightly is becoming its

Continued on page 11

New Child Pacer Implant Method Developed



Procedure developed by a Johns Hopkins team lessens "tremendous morbidity" of child pacer implantation. Electrode is placed via transthoracic or transdiaphragmatic route, since transvenous electrodes are too large for young patients. Preperitoneal pocket created below abdominal musculature compensates for subcutaneous tissue lack in children. **See page 3 for full story.**

NCI Official Cites Questions On Cancer Immunotherapy

By FRANCES GOODNIGHT
Medical Tribune Staff

NEW YORK—Although immunotherapy is the "newest and one of the most exciting" approaches to cancer treatment, a leading specialist in cancer studies cautioned here that many questions about its action, effectiveness, and possibly chronic toxic effects are still unanswered. (See *Editorial*, page 7, MT, Dec. 24, 1975.)

Dr. Stephen K. Carter, deputy director of the National Cancer Institute's

Continued on page 12

Hospitalization Avoided

Heparin, Given By Self, Treats Phlebitis Safely

By NATHAN HORWITZ
Medical Tribune Staff

ANAHEIM, CALIF.—A 10-year study of outpatient, self-administered heparin therapy in acute and subacute thrombophlebitis suggests that this regimen is "effective and safe" and may end the need for hospitalizing all but "the most severe, toxic cases of thrombophlebitis or suspected pulmonary embolism," the American Heart Association was told here.

Experience with 407 patients, in what is believed to be the first long-term study of its kind, showed that ambulatory heparin treatment produced symptomatic resolution within two months in more than 50% of the series and in under six months in 78%, according to Dr. Richard M. Stillman, Instructor in Surgery, Downstate Medical Center, Brooklyn.

Complications Minimal

Only 4% of the group failed to respond to the therapy, and complications in the overall series have been minimal, the investigator said. Approximately three quarters of the patients were free of recurrence at the time of the report.

"Nearly all of the patients were able to continue a relatively normal life and employment during the course of their illness because we do not prescribe bed rest," Dr. Stillman said. "In fact, exercise is encouraged."

In detailing the study, Dr. Stillman noted that standard treatment of acute thrombophlebitis usually calls for prolonged hospitalization "although there has been no controlled prospective

Continued on page 15

Year of Strife Marks British Health Service

Medical Tribune World Service

LONDON—British doctors have just emerged from a year of strife that has almost brought the UK's much vaunted National Health Service (NHS) to a state of complete collapse.

1975 will go down as the year that many of the country's 11,000 senior hospital-based specialists, or consultants, together with 19,000 junior doctors, or residents, engaged in what some physician observers regard as undignified public conflict with their "boss," the Secretary of State for Social Services, Mrs. Barbara Castle.

Two issues emerged: the demand of

Continued on page 18

Seventy-three year old man was one of 28 patients transferred from Hove General Hospital, Hove, England, when three area hospitals closed down after doctors began treating emergencies only during National Health Service crisis.

Sorbents: Treatment for Kidney, Liver Disease ?

By ANASTASIA TOUFEXIS
Medical Tribune Staff

NEW YORK—Sorbents, such as charcoal and oxystarch, may eventually be used to treat patients with chronic kidney or liver disease, according to participants at an international symposium on sorbents held at Downstate Medical Center in Brooklyn.

Sorbents, often described as "chemical blotters," are insoluble substances able to bind gases, liquids and solids to their surfaces. Researchers are taking advantage of this adsorptive capacity in experiments using sorbents to remove toxic solutes such as urea from the blood. They hope that the results of this work will eventually offer kidney patients an alternative to dialysis or kidney transplantation and lead to an effective therapy for patients with chronic liver disease.

Institutionalized Danger

The conference was organized partly because many physicians are beginning to recognize "a distinct danger that hemodialysis may become 'institutionalized,'" said Benjamin T. Burton of the Artificial Kidney-Chronic Uremia program of the National Institute of Arthritis, Metabolism, and Digestive Diseases (NIAMDD), in introductory remarks. He referred to the possibility "that satisfied with what we have wrought in this field, we will pile small improvements on top of other minor advances in dialysis technology and that ultimately the technology of end-stage renal disease therapy will become entrapped in its own net for the lack of breakouts in new directions."

Physicians are also concerned that no truly effective treatment for chronic liver ailments exists. "The improved survival of patients with acute and chronic renal disease stands in sharp contrast to the continuing grim outlook for patients with liver failure," noted Dr. Paul D. Berk of the Section on Diseases of the Liver at NIAMDD. "The knowledge of basic organ physiology and the understanding of the pathophysiology of organ failure which were the basis for the development of successful dialytic therapy for renal insufficiency are not available for the liver. To date, none of the approaches tested clinically have conclusively proved to be of benefit in the setting of fulminant hepatic failure."

Sorbent Uses

Investigators are testing sorbents in kidney- and liver-failure patients in the following ways:

- Intestinal sorbents, such as charcoal, oxystarch, aluminum hydoxide and potassium-binding resins, are orally administered to patients with kidney disease to determine whether the bowel can substitute for the kidney in removing nitrogen compounds from the blood.
- Sorbents, particularly charcoal, are added to hemoperfusion systems used to purify the blood in cases of barbiturate and salicylate poisoning and in patients with liver failure.
- Researchers, aware that various sorbents decrease the volume of dialysate required to cleanse the blood of impurities, are attempting to develop a portable wearable artificial kidney, a prototype of which was demonstrated at the conference by Dr. Willem J. Kolff director of the Division of Artificial Organs at the University of Utah College of Medicine in Salt Lake City, and inventor of the artificial kidney.

Although sorbents were used as poison antidotes as early as 100 B.C., interest in their application to kidney and liver patients began only in the last decade. In 1964, Dr. Hippocrates Yatzidis of Aretaieon University Hospital in Athens treated 12 patients in chronic renal failure with 20 to 50 gm of powdered charcoal daily, given orally with a 40 gm protein diet.

According to Dr. Yatzidis and his colleague, Dr. Dimitrios Oreopoulos, presently at Toronto Western Hospital, Ontario, Canada, "small but significant changes were observed in serum phenols, uric acid and guanidines. In contrast, levels of urea, creatinine, organic acids and electrolytes showed no significant change."

Patients also showed "marked subjective improvement of gastrointestinal symptoms and signs, such as anorexia, nausea, vomiting and uremic odor.

"These findings suggested that the oral use of charcoal might be a useful adjunct to other treatments, but could not be substituted for chronic dialysis," the investigators recalled.

However, the reported benefits of oral charcoal in kidney failure have not as yet been confirmed by other researchers.

Oxidized Starch

In 1971, Dr. Carmelo Giordano of Naples, Italy, produced a new sorbent by boiling corn starch with periodic acid. The oxidized starch, now known as oxystarch, was given to uremic patients on conservative and dialysis treatment regimens.

Results of these trials indicated that 20 gm daily doses of oxystarch lowers blood urea nitrogen levels by binding nitrogenous wastes in the gut, thereby increasing fecal nitrogen content.

Controlled studies by a number of investigators have since confirmed Dr. Giordano's initial findings. One such trial was reported at the conference.

In a study at Downstate Medical Center, four stable uremic adults whose endogenous creatinine clearances ranged from 8 to 17 ml/min were treated for three two-week periods first with 35 gm oxystarch, then with 35 gm oxystarch and 35 gm charcoal, and finally with 35 gm oxystarch and 35 gm charcoal and 200 mg dioctyl sodium sulfosuccinate. The sulfosuccinate was added to the regimen to determine whether a detergent could induce greater sorbent efficacy. The oxystarch and charcoal were contained in fruit puree such as applesauce, given at bedtime, breakfast, lunch and supper. The total metabolic balance was studied.

Dr. Eli A. Friedman reported that his team found "a significant increase in fecal nitrogen excretion from a mean control of 1.5 gm/24 hours to 3.1 gm/24 hours during treatment with oxystarch. Only insignificant further increases in fecal nitrogen excretion were noted during combined treatment with oxystarch and charcoal."

The researchers also noted a significant increase in fecal potassium excretion during oxystarch treatment, from a control mean of 21.8 mEq/day to 43.6 mEq/day.

"Mean serum cholesterol fell in the group from 200 mg% to 166 mg% and in each patient during combined therapy with oxystarch and charcoal," Dr. Friedman added.

Vital signs, hemogram, serum calcium, phosphorous, uric acid, bilirubin, alkaline phosphatase or serum electrolytes remained unchanged during the study. "Mean BUN fell slightly during each treatment with oxystarch alone or in combination, but serum creatinine levels remained unaltered throughout," Dr. Friedman said.

A marked increase in fecal nitrogen excretion (up to 6.5 gm/day) was observed when sulfosuccinate was added to the sorbent regimen, but since only two patients completed this phase of the protocol, the results were termed "suggestive."

The inefficacy of charcoal in reducing nitrogenous waste levels in blood was attributed to the coating of charcoal's adsorptive sites by bile acids, intestinal luminal lipids and triglycerides. This would result in reduced serum cholesterol concentrations, as observed, and prevent adsorption of nitrogen-containing compounds, including uric acid and creatinine, Dr. Friedman explained.

However, he added, "before discarding the potential value of charcoal in uremic patients, a trial of microencapsulated orally ingested activated charcoal is indicated. Prevention of lipid saturation of binding sites may facilitate the *in vivo* extension of in vitro experiments indicating that charcoal may be beneficial in extracting nitrogenous wastes.

"Reducing serum cholesterol in uremic patients, especially if associated with a fall in triglycerides, may in itself be reason for treatment with unencapsulated activated charcoal," he continued. "Recognition that the mortality due to an increased incidence of coronary artery disease in long term dialysis patients is associated with elevated blood triglyceride and cholesterol levels underscores the need to develop a rational means of lowering this risk. A lipid lowering regimen beneficial to the uremic patients would be worth evaluating in other hyperlipidemic states," he concluded.

Coauthors of the report are Dr. Martin J. Saltzman, Monica M. Beyer, and Dr. Alan S. Josephson.

Prototype of portable wearable hemodialyzer is demonstrated by Dr. Willem J. Kolff, inventor of artifical kidney, and patient Kathy Moulton at sorbent symposium. Use of charcoal cartridge to absorb impurities reduces amount of dialysate needed to 20 liters. Device weighs only seven pounds.

Fatal Toxic Reaction Linked to Gout Drug

Medical Tribune Report

CHICAGO—Allopurinol, used in the treatment of gouty arthritis, may cause a serious, possibly fatal, skin reaction in patients on multiple drug therapy, according to Drs. Michael H. Ellman, David F. Fretzin, and Walter Olson of the Michael Reese Hospital and Medical Center here.

Three Patients

Toxic epidermal necrolysis (TEN) developed in three patients within a month of being placed on allopurinol. One 76-year-old woman, who also received an antibiotic for a urinary infection, died. The others were a 60-year-old woman who was also taking antihypertensive medication, and a 45-year-old man on an oral hypoglycemic drug and antibiotics.

"Although we are unable to prove unequivocally that allopurinol caused TEN in our three patients, it is highly suspect," the investigators said. "The probable association between allopurinol and TEN should alert clinicians using this drug to such a complication. Care should especially be taken in patients with chronic illness or in a debilitated state and who are receiving multiple drug therapy."

New Pacer Implantation Method Lessens Morbidity in Children

Medical Tribune Report

NEW ORLEANS—A new, easier and cosmetically more acceptable method for implanting permanent pacemakers in children has been developed by a Johns Hopkins team.

The procedure, based on a 14-year study, emerged in an effort to lessen the "tremendous morbidity" entailed in implanting a pacemaker in a child, especially a young child, the Southern Thoracic Association was told here by Dr. James S. Donahoo, Assistant Professor of Surgery.

Among the problems encountered in 13 children who received 27 pacemaker implantations, Dr. Donahoo reported, were the lack of adequate subcutaneous tissue for a conventional pacemaker pocket, the need for repeated reoperation to change pulse generators, and the fact that smaller, child-size units mean less power, therefore more frequent changes than in adults.

Pocket Created

In the Baltimore group's new implantation method, which has been successfully employed in eight of the 13 children, with followup of up to seven years, the electrode is placed via a trans-thoracic or trans-diaphragmatic route, since transvenous electrodes are too large to be used in very young patients. The lack of subcutaneous tissue is dealt with by creating a pre-peritoneal pocket below the abdominal musculature, Dr. Donahoo declared. This not only provides for easy access in case of erosion, infection or the need for pulse-generator change but is cosmetically more acceptable, the surgeon noted.

"We have experienced no difficulty with changing the box after this approach, and the pacemakers have not tended to erode or migrate in this position," Dr. Donahoo said.

The pacemaker now used by the group is a small "yo-yo" model which is a disc-shaped device with a circumferential groove that accommodates one or two loops of wire. The groove feeds out the wire as the child grows.

"The frequency of pulse generator change can be extraordinarily problematical in a child," Dr. Donahoo observed. "Whereas the average age of implantation in adults is 67 years, the average age for implantation of pacemakers [in our series] was 5.4 years, which means, if the patients live a normal life span of 70 years, that there will be a large number of pacemaker changes."

Rechargeable Device Studied

The team is currently studying the clinical application of a recently-developed rechargeable pacemaker designed by the Johns Hopkins Applied Physics Laboratory, Dr. Donahoo said. The unit is intended to last 10 to 20 years. It is smaller than the conventional pacer and is recharged weekly by an induction coil placed on the skin overlying the pulse generator. Dr. Donahoo observed that in very early trials in a small number of patients, the youngsters "take great delight in the electronic machinations required to recharge the pacemaker."

False-Positive TB Tests

Medical Tribune Report

CLEVELAND—Fewer false-positive results in TB skin tests may emerge from studies by Dr. Thomas M. Danile, Professor of Medicine, and associates at Case Western Reserve University School of Medicine. The CWRU team has shown that three carbohydrates common to *mycobacterium tuberculosis* and to a large number of other bacteria are capable of causing skin reactions in sensitized guinea pigs.

"Now that we've identified what we want to get rid of, we can make significant progress toward developing a more specific TB skin test," Dr. Daniel said.

Portable Bypass Unit

► A battery-powered, portable, cardiopulmonary bypass unit, used at the bedside of the patient who otherwise would die, may very well "extend the limits of the art of resuscitation," a Baylor University team declared at the New Orleans meeting.

Detailing experience with 39 patients whose condition precluded transport to the OR, the team reported that 19 with massive pulmonary emboli, 10 with extensive cardiopulmonary trauma, two with massive drug overdose and two in cardiogenic shock from acute myocardial infarction were all "successfully placed on cardiopulmonary bypass at their bedsides within 15 minutes of cardiac arrest."

Of the others, six patients in cardiac arrest and suspected massive pulmonary emboli were found to have no mechanical cause for the arrest.

The significant point was that "the portable unit allows for orderly transfer, evaluation and therapy," said Dr. Arthur C. Beall Jr., Professor of Surgery in the Cora and Webb Mading Department of Surgery.

13 Patients Salvaged

He noted that 13 of the patients with massive pulmonary emboli were salvaged, and that in eight of 10 with massive traumatic thoracic injuries, the portable bypass unit made it possible to control hemorrhage and perform the needed repair to allow for discontinuance of bypass.

In discussion, Dr. Beall observed that "there have been questions regarding the applicability" of this modality, but stressed that as prehospital monitoring of cardiac and physiologic events becomes more widespread, trained emergency technicians more numerous, and extracorporeal perfusionists more readily available in emergency department surgical staffs, "the extension of the art and science of cardiopulmonary bypass to moribund patients in emergency situations, be it in the trauma center or the hospital ward, is a logical development."

Coauthor was Dr. Kenneth L. Mattox.

Aid to Handicapped

New portable biofeedback device for use by handicapped patients to help them "turn on" paralyzed muscles is demonstrated by Dr. John V. Basmajian, of Emory University, its principal inventor and developer.

Manipulation of Bio Clock Seen Longevity Hope

Medical Tribune Report

NEW YORK—Increasing human longevity within the next 50 years depends upon 1) significantly better cure rates for cardiovascular diseases, stroke, and/or cancer, and/or 2) significant advances in ability to manipulate man's "biologic clock," Leonard Hayflick, Ph.D., said here recently. He strongly favored the latter approach.

Dr. Hayflick, Professor of Medical Microbiology at Stanford University School of Medicine, spoke at a symposium on aging in the year 2025, sponsored by Hoechst-Roussel Pharmaceuticals, Inc.

Even if elimination of cardiovascular diseases, stroke, and cancer would add some 20 years to man's life expectancy, he said, "the greatest potential impact on human longevity would be research directed towards reducing the rate of the fundamental non-disease-related biologic causes of age changes, which are undoubtedly genetically determined."

DR. HAYFLICK

However, "the likelihood that either or both of these events will occur in the next 25 to 50 years is, in my judgment, very doubtful," he said.

It would be more feasible to experiment with "immediate possibilities" for living longer, he suggested. These include undernutrition (but not malnutrition), anti-oxidants, and less sleep.

While it has been known for 40 years that caloric reduction in a number of experimental animals increased their lifespan by as much as 50%, "no human has consciously chosen to do it."

The age-decelerating effects of anti-oxidants is another potential field of study, especially since anti-oxidants are

Continued on page 19

index

Medicine:
1,2,4,9,14,15,19,20,21,23

Self-administered heparin found "effective and safe" 1
Cancer immunotherapy: unanswered questions 1
National Health Service in Britain emerging from year of strife 1
Medical Tribune's Editorial Credo 1
Fatal toxic reaction linked to gout drug 2
Kidney and liver disease may be treated with sorbents 2
Chronic pain patients misuse drugs 4
Device eliminates need for O_2 cylinders 4
Immunologic parallel seen in cancer and rheumatoid disease 9
More physicians respond to Dr. Lasagna's letter 14, 15
Pancreatic disease diagnosis not aided by 3 tests 20
Myasthemia gravis may be a humorally mediated autoimmune disease 21
Sarcoidosis linked to elevated angiotensin-converting enzyme 21
Ban on motorcycles asked to reduce highway deaths 23

Surgery: 12
EACA withdrawal favored in intracranial aneurysms 12
Use of stapler simplifies abdominal hysterectomy 15

Obstetrics: 18
SIDS mothers have difficulty conceiving replacement child 18

feature index

Editorials 1, 11
Editorial Capsules 5
Current Opinion 9
Book Biopsy 11
Letters to Tribune 11
Eliot Janeway 19
One Man . . . and Medicine 20
Epigram 20
Medicine on Stamps 20
Wine Talk 22
Immateria Medica 23

Medical Tribune

CHRIS WOODBURY, Ph.D.
General Manager

HARRY HENDERSON, *Editor-in-Chief*
RICHARD GUBNER, M.D. *Associate Editor*
HAROLD FOSNOT, *Executive News Editor*
JOHN HEWITT, *Associate News Editor*
WILLIAM PRIFTIS, *Art Supervisor*
ANN CONNER, *Picture Editor*

ARTHUR M. SACKLER, M.D.
International Publisher

Advisory Board
JOHN ADRIANI, M.D. • RENE J. DUBOS, Ph.D.
JULES H. MASSERMAN, M.D.
BERNARD LOWN, M.D.
ALBERT B. SABIN, M.D.
ALTON OCHSNER, M.D.
ROBERT A. CHASE, M.D.
LEO G. RIGLER, M.D.

880 Third Avenue, New York, N.Y., 10022
[redacted] • Telephone: 421-4000

Circulation audited by Business Publications Audit of Circulation, Inc.

MEDICAL TRIBUNE *is published each Wednesday except on March 31, June 2, June 6, June 16, June 30, July 14, July 28, Aug. 11, Aug. 25, Sept. 29, Dec. 1, Dec. 22, Dec. 29, by Medical Tribune, Inc., 880 Third Ave., New York, N.Y., 10022 Controlled circulation postage paid at Vineland, N.J. 08360 Subscriptions $25.00, Students $7.50.*

Most Chronic Pain Patients Misuse Drugs, Study Shows

By HILDA LASS
Medical Tribune World Service

FLORENCE, ITALY—Study of patients with chronic pain "suggests that the majority misuse whatever drugs they are given, and a significant percentage abuse drugs regularly in spite of appropriate instructions from their physicians," according to Dr. Don M. Long, Professor of Neurosurgery at Johns Hopkins University Medical School.

He made this point at the First World Congress on Pain Research and Therapy here, noting that withdrawal of all harmful drugs is mandatory for patients taking part in the Johns Hopkins Pain Treatment Program.

"It is our practice to warn patients that they must not use drugs in ways other than prescribed. Persistent disregard of these drug recommendations is so regularly a predictor of failure in our program that it now leads to discharge of the patient from further treatment," he declared.

Patient Profile

Patients admitted to the voluntary Johns Hopkins Pain Treatment program are typically from 35 to 55 years old, suffering from intractable back and leg pain, have undergone from three to five back operations including at least one fusion, and are left with a significant neurologic deficit, epidural fibrosis and arachnoiditis. Nearly all are overweight, unable to function without physical distress, cannot sleep, and live in a state of depression and chronic anxiety, Dr. Long said.

A study of the more than 400 patients seen has revealed that on arrival 90% are taking narcotics, 80 are taking psychotropics, and "over half are using antagonistic or incompatible drugs," he said.

"Ninety-seven percent use their medications in an inappropriate fashion irrespective of the advice of their physician. Ninety percent have significant withdrawal symptoms. Forty percent obtain prescriptions from multiple physicians, almost always without informing each physician that another is prescribing," he continued. The drugs most commonly abused are oxycodone and diazepam.

"The principles of our drug treatment program are: the elimination of narcotics, the elimination of barbiturates, and the relief of anxiety, depression and sleeplessness," he explained. "It is our contention that no patient should continue the use of narcotics for the treatment of chronic pain of benign origin and complete withdrawal is necessary except in unusual circumstances."

Narcotics Withdrawn

Narcotics are usually withdrawn within seven days, although with drugs stronger than codeine the process may last 14, methadone being given as a substitute. Barbiturates, which tend to aggravate chronic sleeplessness and, with continuous use, produce muscular and ligamentous pain, are withdrawn within approximately the same time limits, Dr. Long indicated.

While diazepam is a satisfactory anti-anxiety agent, its long term effect is to accentuate depression and therefore, in his opinion, it is not appropriate for use in chronic pain. It, and any other psychotropic medications being used, are usually withdrawn within three to five days.

At the same time, he said, "a program of therapy designed for short-term control of the patient's symptomatology is instituted," consisting of "an anti-anxiety agent, an antidepressant, a hypnotic for short-term use, and a non-narcotic analgesic."

The anti-anxiety agent generally administered is fluphenazine hydrochloride in 1 mg doses orally three times daily. Amitryptyline HCl, given at bedtime, usually corrects insomnia in two to four days, although its antidepressant effect takes several weeks to become manifest, Dr. Long said.

The anti-anxiety agent is usually continued for from six weeks to three months and the antidepressant for from three to six months, discontinuation being carefully monitored. During the first week after admission, until insomnia is corrected, the hypnotic flurazepam hydrochloride may be given, while acetaminophen is commonly substituted for a narcotic analgesic during the withdrawal period.

Propoxyphene hydrochloride and pentazocine lactate are rarely given. Pentazocine given parenterally "appears to be one of the most difficult drugs to withdraw because of its significant psychic effects," Dr. Long said. "An attempt is made to eliminate the patient's psychic need for medication for pain relief.

"Drug withdrawal is undertaken without regard for success or failure of pain relieving procedures. Control of drugs is mandatory if a successful pain rehabilitation program is to be realized," Dr. Long concluded.

Afferent Stimulation

► Reviewing the current status of electrical stimulation of the peripheral nervous system and the spinal cord for the relief of chronic pain in another report, Dr. Long told the congress that his own experience with externally applied stimulation and a review of the literature indicate that "approximately one-third of patients with intractable pain of benign origin referred to chronic pain treatment centers will respond to this method of therapy."

He added that "it appears to be even more effective in the treatment of pain in patients less seriously incapacitated," and that indications for its use in acute pain need to be more fully explored.

Since the first satisfactory external electrical stimulators became available in 1970, experience with 972 patients has been reported, he said. Thirty-five per cent were satisfactorily treated by external electrical stimulation alone. In a letter survey of 3000 patients, conducted by four major pain treatment centers in the U.S., one-third reported complete relief with electrical stimulation and another one-third improvement, he continued.

Treatment has been empirical, stimulation being applied around painful areas or over major nerve trunks destined for these areas.

A more recent development is the use of implantable devices for chronic stimulation of peripheral nerves, preceded by temporary stimulation of peripheral nerves for diagnostic purposes. Cuff electrodes placed around the nerve and then attached to a conveniently placed subcutaneous radio receiver have given complete relief in about 50% of cases so far reported, Dr. Long went on.

Failures Described

Discussing his own series of 34 patients, of whom 17 obtained full and 7 partial relief, Dr. Long said that the majority of failures occurred in sciatic nerve implants which relieved leg but not low back pain resulting from multiple spinal injuries. "The use of a peripheral nerve stimulator appears to constitute the method of choice for the treatment of pain of nerve injury origin," but is less useful in pain which is not confined to the distribution of a single injury nerve, he said.

In dorsal column stimulation with an implanted device, electrodes have been placed in the subdural-subarachnoid space, the subdural extra-arachnoid space, within the dura, and in the epidural space, he continued. Varied placement and types of electrodes have not appeared to influence success. Of

Continued on page 9

Canadian Device Harnesses Ambient Oxygen

Medical Tribune World Service

MEXICO CITY—A device developed by Canadian engineers that makes it possible to obtain oxygen-enriched air from environmental air in the home for therapeutic purposes, thereby eliminating the need for conventional oxygen cylinders, was described at the 23rd Conference of the International Union against Tuberculosis.

Patients with chronic respiratory disease needing continuous oxygen therapy can plug this apparatus into an ordinary wall outlet and, using standard hose and nasal prongs, receive almost pure oxygen at flow rates of up to 4 liters a minute.

The machine was first tested clinically in 1971 in Canada. Subsequently, it has been the subject of a full-fledged program under way since 1974 throughout the province of Alberta, under the sponsorship of the provincial government.

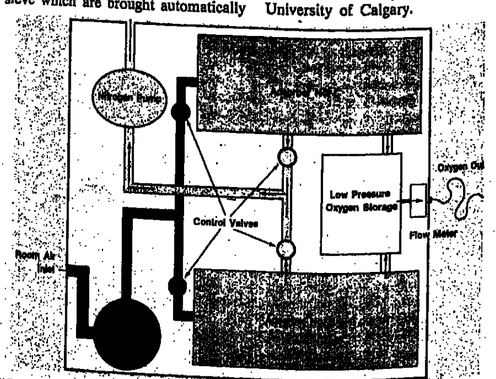
Summarizing his observations in 30 patients with hypoxic respiratory failure who utilized the system, Dr. David T. Shaw, Assistant Professor of Medicine, University of Calgary, Alberta, reported that "We have found it highly acceptable to patients and those who have already used bottled oxygen prefer it because of the elimination of the practical problems in obtaining the regular commercial supply of replaceable tanks."

Other advantages of the mechanism were described as being: low relative cost with as much as 60% savings over cylinders; no fire hazard because of no storage of gaseous or liquid oxygen; particularly beneficial for persons in out-of-the-way places; medically secure since impossible to have an oversupply.

Absorption Employed

Called an "oxygen separator," it employs the principle of adsorption to effect the extraction of nitrogen, carbon dioxide, and water vapor from the air while permitting the passage of almost pure oxygen. The separator consists essentially of two beds of molecular sieve which are brought automatically into alternate operation at two-minute intervals, thus permitting the removal, under vacuum, of adsorbed nitrogen from one sieve while the other is engaged in the production of oxygen. By this means, a constant supply of 90% O_2 with 4.5% argon and 5.5% nitrogen is maintained indefinitely.

Larger machines with higher outputs and the same characteristics for use in institutions needing greater supplies are considered feasible and being studied by the inventor, Dr. Robert Ritter, former Dean Faculty of Engineering, University of Calgary.



"Oxygen separator" employs two beds of molecular sieve, alternating at two-minute intervals, to effect the extraction of nitrogen, carbon dioxide, and water vapor from the air while permitting the passage of almost pure oxygen.

EDITORIAL DIGEST

. . . brief summaries of editorials or comments in current medical and scientific journals.

Confirming Celiac Disease

"The one-hour xylose test has had a controversial life. In 1973 it was hailed as a simple, effective screening test. It is certainly simple, requiring only one estimation of blood xylose after an oral dose of xylose given to the fasting patient. A normal one-hour xylose level was said to exclude celiac disease if the patient was receiving gluten at the time of the test. Then workers in other centres failed to confirm its reliability. It seemed to be a test that only the specialised unit could use with confidence. Recently [J.M.] Littlewood (*Arch. Dis. Child. 50: in press*) has put the test into a better perspective: using it on a general paediatric ward and adopting less stringent criteria for xylose malabsorption (all celiacs had a one-hour xylose below 30 mg/dl) he found it to be a useful screening test.

"The report from Birmingham (*Arch. Dis. Child. 50:259, 1975*) of the usefulness of the test after gluten challenge for children previously diagnosed as having celiac disease may be an important contribution. At the least it seems to provide a useful way of selecting the optimal time for the confirmatory biopsy. But the history of problems and controversy associated with the one-hour xylose test makes it important that confirmation of the Birmingham results should come from elsewhere." (*Editorial, Br. Med. J. 2:2, Oct. 4, 1975*)

The Immunization Failure

". . . McDaniel, Patton, and Mathers demonstrate that less than 40% of active patients of pediatricians whose practices were studied had completed recommended immunizations by the age of 2 years. The finding is surprising and ominous. Most pediatricians would estimate that a far higher proportion of children in their own practices were immunized . . .

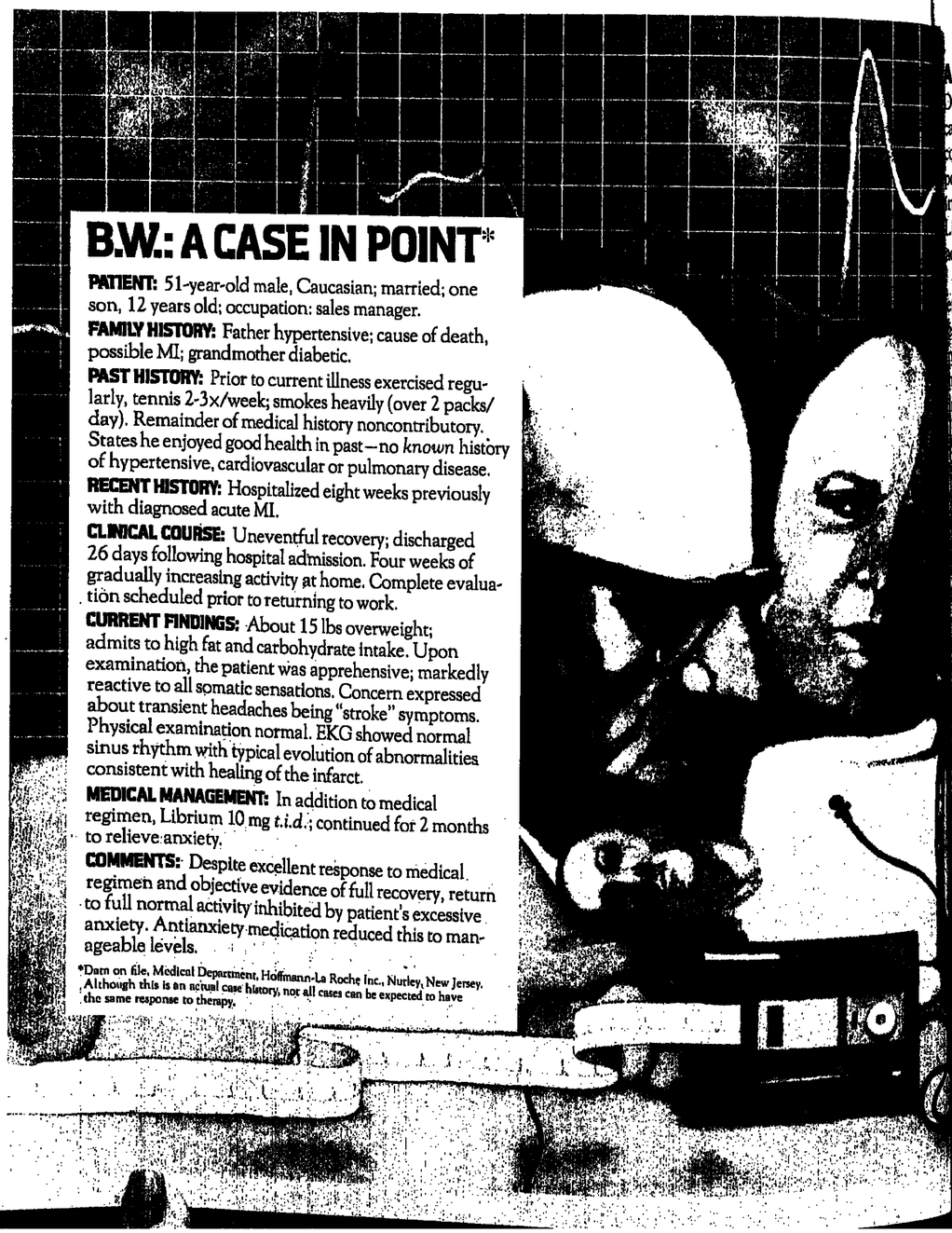
"Parents must be motivated to bring their children for preventive care. Dentists send their patients notices to come in for semiannual check-ups. Veterinarians remind pet owners to bring their dog or cat for rabies immunization. Why are such reminders not routinely used by pediatricians? . . .

"In our society, responsibility for immunizing an infant must ultimately rest with the parents. However . . . Parents are unlikely to seek preventive care for their children . . . until such information impinges on their consciousness. . . .

"In an age when, through ingenious advertising, public demand can be created for a host of useless, expensive, and potentially hazardous 'health' products, surely a demand could also be created for as efficacious, inexpensive, and beneficial a 'product' as immunization. It is our profession's responsibility to create that demand." (*Commentary, Edgar K. Marcuse, M.D., M.P.H., Pediatrics 56:493, Oct., 1975*)

LIBRIUM® AT WORK: (chlordiazepoxide HCl)

IN THE ANXIOUS PATIENT WITH ORGANIC CARDIOVASCULAR DISEASE



B.W.: A CASE IN POINT*

PATIENT: 51-year-old male, Caucasian; married; one son, 12 years old; occupation: sales manager.

FAMILY HISTORY: Father hypertensive; cause of death, possible MI; grandmother diabetic.

PAST HISTORY: Prior to current illness exercised regularly, tennis 2-3x/week; smokes heavily (over 2 packs/day). Remainder of medical history noncontributory. States he enjoyed good health in past—no *known* history of hypertensive, cardiovascular or pulmonary disease.

RECENT HISTORY: Hospitalized eight weeks previously with diagnosed acute MI.

CLINICAL COURSE: Uneventful recovery; discharged 26 days following hospital admission. Four weeks of gradually increasing activity at home. Complete evaluation scheduled prior to returning to work.

CURRENT FINDINGS: About 15 lbs overweight; admits to high fat and carbohydrate intake. Upon examination, the patient was apprehensive; markedly reactive to all somatic sensations. Concern expressed about transient headaches being "stroke" symptoms. Physical examination normal. EKG showed normal sinus rhythm with typical evolution of abnormalities consistent with healing of the infarct.

MEDICAL MANAGEMENT: In addition to medical regimen, Librium 10 mg *t.i.d.*; continued for 2 months to relieve anxiety.

COMMENTS: Despite excellent response to medical regimen and objective evidence of full recovery, return to full normal activity inhibited by patient's excessive anxiety. Antianxiety medication reduced this to manageable levels.

*Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, New Jersey. Although this is an actual case history, not all cases can be expected to have the same response to therapy.

CLINICAL ANXIETY AND THE CARDIAC PATIENT

During cardiac convalescence, the patient's anxieties can often be allayed through your reassurance and counseling and his family's encouragement and support. In some patients, however, excessive anxiety can interfere with medical management. When this occurs, Librium (chlordiazepoxide HCl) may be a beneficial adjunct.

Librium offers a high degree of antianxiety effectiveness and is used as an adjunct to primary cardiovascular medications. It also provides a wide margin of safety. In proper dosage, Librium usually helps calm the overanxious patient without unduly interfering with mental acuity or general performance. Initial therapy should be limited to the smallest effective dosage, particularly in the elderly and debilitated patient, to preclude development of ataxia or oversedation. And Librium therapy should be discontinued when anxiety has been reduced to tolerable levels.

Librium is used concomitantly with certain medications of other classes of drugs, such as cardiac glycosides, diuretics, antihypertensive agents, vasodilators and anticoagulants. While rare reports of variable effects on blood coagulation in patients receiving oral anticoagulants and Librium have been noted, clinical studies have not established a cause and effect relationship.

WHEN CLINICAL ANXIETY INTERFERES WITH PATIENT MANAGEMENT

LIBRIUM® (chlordiazepoxide HCl/Roche

5 mg, 10 mg, 25 mg capsules

FOR ALL THE RIGHT REASONS

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Holiday Greetings and Thanks to Our Contributors and Collaborators from the Editors and Staff of

Medical Tribune

To the hundreds of physicians in all specialties, as well as university and hospital staffs, who aid us in the interest of informing the medical profession, we send holiday greetings and best wishes for the coming year.
We would particularly like to thank those specialists who prepared answers to questions posed in our IN CONSULTATION column. These contributors to the postgraduate education of fellow physicians include the following:

Epilepsy diagnosis and treatment

DR. LOUIS D. BOSHES
Clinical Professor of Neurology, University of Illinois Medical Center, Chicago; Coauthor, with Dr. Frederic A. Gibbs, of "Handbook of Epilepsy"

Breast cancer

DR. DANIEL BURDICK
Clinical Professor of Surgery, State University of New York Upstate Medical Center, Syracuse, N.Y.

Prophylactic use of antibiotics in gynecologic surgery

DR. CLIFFORD R. WHEELESS, JR.
Department of Gynecology and Obstetrics, The Johns Hopkins University and Hospital, Baltimore, Md.

Puberty studies

DR. ALLEN W. ROOT
Director, University Service, and Professor of Pediatrics, University of South Florida, St. Petersburg

Hematology and pure red cell aplasia

DR. LARRY WATERBURY
Head, Hematology Section, Baltimore City Hospitals, Baltimore, Md.

Rubella immunization

DR. ALLAN J. EBBIN
Associate Professor of Pediatrics, Los Angeles County—University of Southern California Medical Center

Diffuse obstructive polmonary syndromes

DR. C. J. MARTIN
Director, Institute of Respiratory Physiology, Virginia Mason Research Center, Seattle, Wash.

Multiple sclerosis

DR. GEORGE A. SCHUMACHER
Professor of Neurology, University of Vermont Medical Center Hospital, Burlington; Member, Medical Advisory Board, National Multiple Sclerosis Society, New York

Asymptomatic carotid bruits

DR. JESSE E. THOMPSON
Department of General Surgery, Baylor University Medical Center, Dallas, Tex.

Sunglasses

JAY M. ENOCH, PH.D.
Graduate Research Professor, Department of Ophthalmology, University of Florida College of Medicine, Gainesville

Management of heart failure

DR. JAY N. COHN
Professor of Medicine, and Head, Cardiovascular Section, University of Minnesota Hospital, Minneapolis

Ophthalmology

DR. ANTONIO R. GASSET
Assistant Professor of Ophthalmology, University of Florida College of Medicine, Gainesville

Food allergy

DR. CLAUDE A. FRAZIER
Author of "Coping with Food Allergy" and "Insect Allergy," Asheville, N.C.

Polymyalgia rheumatica and rheumatoid arthritis

DR. CHARLES M. PLOTZ
Chairman, Department of Family Practice, and Professor of Medicine, State University of New York Downstate Medical Center, Bklyn, N.Y.

Hemophilia

DR. JAMES STENGLE
Deputy Director of Medical Affairs, NIH Lister Hill National Center for Biomedical Communications, Bethesda, Md., and Chairman, Medical and Scientific Advisory Council, National Hemophilia Foundation, New York

Amniotic fluid problems

DR. LOUIS GLUCK
Professor of Pediatrics, University of California School of Medicine, La Jolla

Early detection of osteoporosis

ANTHONY A. ALBANESE, PH.D.
Director, Nutrition and Metabolic Research Division, Miriam Osborn Memorial Home, Rye, N.Y.

Current Opinion

On Dr. Sidney Wolfe's Testimony On the Implanted Plastic Lens

DR. SIDNEY WOLFE, director of the Ralph Nader backed Health Research Group testified before the House subcommittee on health, according to the *San Francisco Chronicle* account from United Press International, that insufficiently tested plastic lens, inserted in the eyes of some cataract patients, have caused harmful side effects, including loss of the entire eye.

He reportedly said: "Many ophthalmologists think they have never been properly tested in animals or clinically investigated by multiple ophthalmologists. As a result, the implantation of IODs (intraocular devices) has resulted in serious damage to the eyes of many patients, including glaucoma, severe corneal disease, inflammation and infection."

The press report said that Dr. Wolfe described the problem as arising only with plastic lenses that are surgically implanted in people whose natural lenses had to be removed, usually because of cataracts.

Dr. Wolfe's comments prompted the following "Current Opinion" editorial from Dr. Miles Galin, Professor of Ophthalmology at New York Medical College:

Dr. Sidney Wolfe, an internist, has done ophthalmology and medicine in general a great disservice by presenting superficial and non-pertinent information to a Congressional group.

When queried directly, Dr. Wolfe stated that the United Press International summary of his presentation did not carry the true tone of his submission. A direct reading of his submission does not corroborate his statement and points out either a defect in his knowledge on the subject or an absence of scientific method.

Intraocular lenses, which were first implanted in 1949, are of many types. Virtually all lenses that are used today are lenses that rest in the pupillary space. They are held in this area by loops which are either anterior or posterior to the iris or by allowing the posterior capsule of the lens to remain and having loops fit between the iris and this capsule. Such lenses have been in extensive use in Europe for at least 10 years and in ever-increasing numbers in the United States for the past approximately seven to eight years.

In no single instance, has there ever been a report of bioincompatibility between these lenses and an eye. As soon as the problem of lens corneal touch was eliminated by designing pupillary lenses without loops that came near the cornea, complications of the procedure, which were always mechanical, were essentially eliminated.

IN EXTENSIVE STUDIES performed at New York Medical College comparing the long-term results of cataract extraction without implants, cataract extraction with contact lenses and cataract extraction with pupillary implants, there has been no statistical difference in the groups with respect to complications or success but a distinct difference in the function of patients who are inestimably better off with intraocular lenses. Dr. Wolfe quoted a study published in December of 1969 reviewing the pathological findings of 17 eyes which had implant procedures. In not one single case was a pupillary lens used. Consequently, Dr. Wolfe presented information concerning implants that are not used in the United States and concluded *from this that implants* presently used in the United States were dangerous.

Most citizens believe that an open forum is valuable and that physicians too should participate in such forums, as Dr. Wolfe has done. The bending of the truth to win a point—or an absence of knowledge of the subject—is not representative of the American process.

Patients in Chronic Pain Found Misusing Drugs

Continued from page 4

489 patients reported by various investigators, 18% have achieved excellent relief, 37% satisfactory relief, for an overall success rate of 55%.

Follow-ups indicate, however, that at two years only 18% remain free from pain, he added. Furthermore, the complications are "those expected from a major procedure requiring thoracic laminectomy," and include paraplegia, cerebrospinal fluid fistula, and infection. Late failure of devices is common, he added.

Dorsal Stimulation

"It appears," he warned, "that dorsal column stimulation is currently a technique which should be reserved for a few individuals skilled in its use and skilled in patient selection, having all the facilities of a chronic pain treatment program at their disposal."

Experience with a modification of this technique using percutaneous placement of epidural wire electrodes, thus eliminating major surgery, is still limited but it suggests that this will be an effective alternative, Dr. Long continued. Stimulation of the anterior surface of the spinal cord has also been tried but not enough data is available to draw conclusions.

Of all the techniques, "External electrical stimulation appears to be the most effective and can be utilized advantageously in any comprehensive pain treatment program," he counselled.

Psychological ills

"Simple relief of pain is not satisfactory therapy for many patients with chronic pain problems," he emphasized. Often the treatment of the psychosocial ills of these patients is mandatory, "and the complete facilities of a chronic pain treatment program are usually required to treat such patients satisfactorily.

"The availability of these kinds of facilities will remarkably reduce the number of patients considered to be candidates for any kind of interventional procedure, and it has been our experience that no more than 10 per cent of such patients admitted to our chronic pain treatment program will be considered as candidates for a major interventional procedure at the present time," Dr. Long concluded.

Immunologic Parallel Seen in Ca and Rheumatoid Disease

Medical Tribune World Service

Sir Frank Macfarlane Burnet, now in his 76th year, carries lightly both his age and the role of éminence grise *in medical research. In a free-ranging interview with* MEDICAL TRIBUNE, *which took place in Helsinki, Finland, during the 8th European Rheumatology Congress, the Australian-born Nobellist and immunologist finds a parallel between cancer and rheumatoid disease, and makes a plea for a more empirical approach to therapy.*

Sir Frank, you have described yourself as a pessimist in regard to the possible success of much of the more tradition-oriented research in rheumatoid disease. Why is this?

Let's put it this way: in medicine we have nearly completed our understanding of disease resulting from the impact of the environment, infections, trauma, malnutrition, poisoning, etc. But in dealing with intrinsic causes, we are more likely to gain understanding by concentrating on genetic aspects and then examining how extrinsic factors like infection, chronic irritation, or physical mutagens modify the situation.

Have you also criticized certain experiments with animal models?

I am a great believer in the experimental approach. However, I do not believe that interpretations drawn from the results of fantastically unbiologic and quite artificial experiments on genetically normal animals are ever directly relevant to autoimmune disease as we see it in man.

Is this because you have your own ideas about the etiology of rheumatoid disease?

It is deeply rooted in Western tradition that every ill has a cause, and in principle if we know the cause we can cure the ill. Therefore, we must find viruses that will cause cancer, autoimmune disease, and old age itself. I believe we should accept biologic realities and seek the answer rather in a combination of factors—environment, genetics, and, as I like to add, somatic genetics.

Would you please elaborate on that?

Think of it as an accident occurring in the cell, allowing the immunocytes —the lymphocytes concerned with immunity—to proliferate in a fashion which is not good for the body. You can't have a full autoimmune disease situation unless you have cells that are not subject to normal control, and abnormally accessible autoantigen.

Is that like the cancer process?

The comparison is a fair one—genetic predisposition, a chronic, irritative element which may be a virus but more often is a chemical, and the liability to error that arises when DNA damaged by the carcinogen has to be repaired. So you get uncontrolled cell proliferation, somewhat similar to the proliferation of an immune cell, the resistant T-cell, which will trigger the rheumatoid process. In a very special sense, autoimmune disease is a kind of malignancy.

Then would it be fair to conclude that there is little prospect of preventing rheumatoid process?

Without wishing to be too dogmatic, I think it is unfortunately true that there has been no great decrease in the incidence of rheumatoid arthritis over the last 50 years of medicine. The genetic predisposition cannot be modified, the accidental modification of the cell is not something we can do anything about, so that leaves you with the environment.

And the environment carries certain specific triggers?

A number of things—one is rubella. In a very small proportion of cases, the disease goes on to become rheumatoid arthritis. But there is also a range of infections, some involving the joint directly, others localized there, which could do it. So it is difficult to envisage a practical approach to prevention.

Could genetic engineering be of any help in prevention?

I cannot see this as a possibility. There are one or two things that might be done... but I cannot see the FDA agreeing to experiments of this sort with human beings.

Is the outlook for therapy any brighter?

Naturally, we must follow the current leads. Climatology offers potential. In terms of scientific medicine, climate may not have a real effect, but the patient often feels better when he gets into a sunny, dry climate, and that is what matters. Still, we must not neglect empiric physiotherapy, or even perhaps psychotherapy. And when the patient's condition warrants it, the surgeon must be brought in. He can do a great deal to combat disablement. Then there are more subtle things—the therapeutic value of domestic happiness, a job that one enjoys doing.

I wouldn't exclude anything that might possibly be of some good, and that could include folk healers, even copper bracelets, if only for whatever psychologic effect they might have. Let's have tests, under proper scientific conditions, of all these things.

Classic medicine has been extraordinarily successful in dealing with the impact of the environment on the body, but when it comes to the chronic, degenerative diseases, we have to learn more about the immune system—how it controls changes in cells, how it controls itself. We need to study how the body reacts to, emotional and other stresses.

Would such studies involve psychologists and psychiatrists?

The psychologist rather than the psychiatrist. I think we should in particular study unresolved aggression in animals.

The Only Independent Weekly Medical Newspaper in the U.S.

Medical Tribune

and Medical News
Published by Medical Tribune, Inc.

To Preserve the Progress of Science

Continued from page 1

overriding concern. Following an editorial on the *Freedom of Inquiry* came one on *Federal Intervention in Universities* and then on *Truth or Power?* As we feared, and as *Science* now finds, it has come to pass that

"It is fashionable to criticize the ethics and humanity of scientists."

It appears previously to have been even more fashionable to criticize the ethics and humanity of practitioners and researchers in medicine. At this time it is enlightening to quote from the three recent *Science* editorials:

Freedom of Inquiry
Science, Sept. 19, 1975

"The First Amendment to the Constitution explicitly forbids the Congress from abridging the freedoms of speech and of the press. It imposes no comparable constraint abridging freedom to learn, to teach, or to inquire; yet these may be construed to be implicit freedoms and indeed seem to be of a comparable quality . . . Some of the consequences of constraining freedom of inquiry are well known. Jacob Bronowski recently reminded us that the loss of Italy's lead position in the Renaissance of science followed immediately upon and doubtless was caused by the adverse judgment of the Inquisition against Galileo, which forbade certain lines of inquiry. In an otherwise impressive forward march of science in the Soviet Union, a generation of genetics research was lost by the constraints resulting from Lysenkoism . . . It is suggested that we treat freedom of inquiry as we have learned to treat freedom of speech . . ."

Federal Intervention in Universities
Science, Oct. 17, 1975

"University presidents and other spokesmen are beginning to state publicly what they have been saying privately. Congress and the federal bureaucracy are increasing their many modes of interference with universities . . . Until about 1960 government involvement in academia was not great and interference was minimal. But in the late fifties grants for research started to become a substantial factor in university budgets . . . Thus, in the seventies the leaders of universities were ill-equipped to deal decisively with Washington and its agents. In consequence, the universities are now forced to cope with laws, proposed laws, regulations, proposed regulations, and authority-grabbing bureaucrats. The laws are proposed and enacted for worthy purposes, such as occupational safety, fair employment, or social security. Each of itself is laudable and defensible. But their total impact on the financial and intellectual life of the universities is severe . . . A saddening development in the federal approach to universities in the past decade has been a shift from offering inducements to threatening punishments . . .

"The irony of punitive federal intervention is that a government which is unable to manage its own affairs competently insists on spreading its own brand of inefficiency throughout higher education. [Our emphasis]

"It is hoped that the university faculties will unite behind their presidents in opposing further federal involvement. A truly unified academic community could halt the federal crippling of higher education."

Truth or Power?
Science, Oct. 31, 1975

"The relationship between the scientific and the political communities is one of constant mutual frustration. There is a feeling on both sides that each ought to be able to help the other . . . Science is a problem-solving subculture whose main value is truth. It is concerned with developing testable statements about the world which in turn create images of the world which correspond to what the world is really like. Problem-solving, therefore, is the main preoccupation of scientists and indeed of the professionals in general whether they be doctor, engineer, architect, or planner . . .

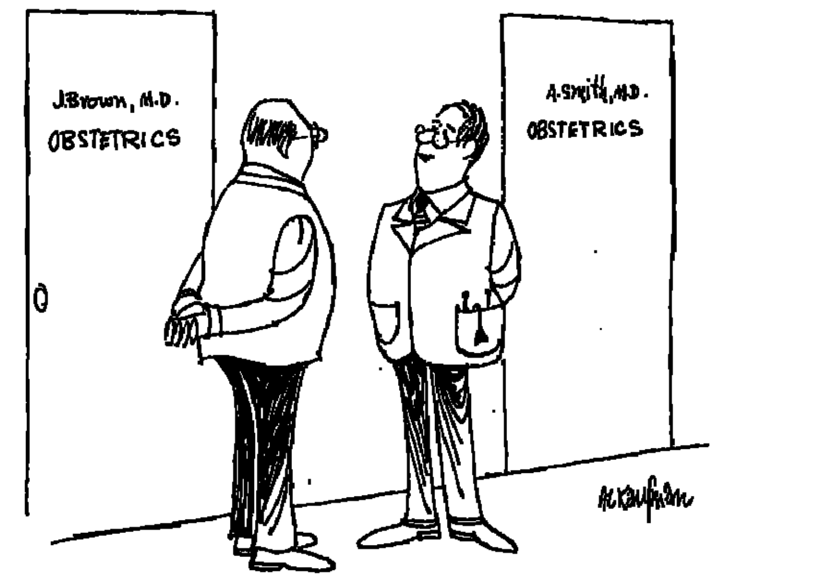
"Arguments ad hominem are considered very bad form in the scientific community and there is a strong ethic of truth-telling and veracity . . . [Our emphasis]

"The culture of the political community is very different. It is dominated in the first place by lawyers who are trained to win cases rather than to solve problems. The lawyers' 'problem' is not to produce testable propositions, but to win the case. For politicians, likewise, the problem is to win elections and to please the majority of their constituents. The 'scientific' problem-solving which is involved in getting the best legislation or the best decisions is incidental to the larger problem of political survival. We should not necessarily blame lawyers and politicians for behaving like lawyers and politicians. . ."

MEDICAL TRIBUNE has clearly articulated these issues over the years (see MEDICAL TRIBUNE's Editorial Credo, page 1). Today, MEDICAL TRIBUNE does not stand alone.

The growing concern of *Science*, as reflected editorially, suggests that at long last the scientific community is awakening to a malignant development whose initial growth was discerned by a few sensitive to its prognoses and whose rapidly proliferating spread threatens the viability of a free, responsible science and medicine, reseach and practice. Individual leaders in science and medicine must be heard from, official organizations, *ad hoc* and other groups must be mobilized to assure an informed public and a responsive political climate so as to preserve the progress of science in a democratic society.

A.M.S.



"When do you think the economy will turn around—In the 2nd quarter or the 3rd trimester?"

LETTERS TO TRIBUNE

Editorial Dialogue

I want to thank you for printing my letter pointing out ambiguities in one of your editorials. That kind of openness and willingness to enter into dialogue demands respect. It is appropriate that a science-oriented publication like yours should set, as it appears to do, a good example to the press in general.

DANIEL STEINBERG, M.D., Ph.D.
Professor of Medicine
Head, Division of Metabolic Disease
University of California
School of Medicine
La Jolla, Calif.

OTC Drugs

Your article on OTC drugs in the issue of October 27th (Vol. 9, #19) was the kind of one sided, poorly researched, potentially inflammatory piece that calls to question your responsibility as a public paper. To extrapolate from the Australian study which showed a small increase in perinatal complications, to a scare column on teratogenicity is unfair to the many young female arthritic patients who must take a daily ration of aspirin.

Aspirin's teratogenicity is well established but only in rodents and in doses a hundred-fold higher than attainable levels in man. In addition, numerous studies such as the British one, neatly buried in your article, have not been able to make an association between aspirin ingestion and any part of the pregnancy sequence, including the status of the infant, months and years after birth.

The OTC warning labels will, one hopes, promote better patient use of drug products but they will only "warn" when there is good evidence.

THOMAS G. KANTOR, M.D.
Clinical Coordinator of the
Rheumatic Disease Study Group
New York University Medical Center
New York, N.Y.

[redacted]

Practical and Theoretical Aspects of Psychoanalysis, *by Lawrence S. Kubie, Revised Ed., International Universities Press, Inc., New York, 1975; $15.*

"During the course of the analysis, the referring physician can rarely be taken fully into the analyst's confidence. In many instances patients themselves are explicit in their requests that nothing of what they tell the analyst should be communicated to their physicians. This can create an awkward situation for the psychoanalyst; but, unless the patient is psychotic or otherwise irresponsible, the analyst's responsibility to the patient must take precedence over his desire to be courteous to his medical colleague. In the course of the analysis, however, it may become clear that the patient's request arose from a neurotic distortion of his attitude toward the family physician. When this is the case, and when his aspect of the neurosis has been resolved, the patient will withdraw his request, leaving the psychoanalyst free, within reason, to take the referring physician into his confidence.

"Certainly a patient's reluctance to have his story passed on to anyone other than the analyst is never entirely neurotic. To expect a patient to unburden himself without reserve in the presence of anyone is asking a great deal. To expect him to do this before two people may be asking the impossible. Yet that is what it would amount to if a psychoanalyst said to his patient, not, 'What you say here is for my ears alone,' but 'What you say here is for my ears and those of your family physician.' The patient's confident sense of privacy cannot be violated in this way without jeopardizing his ability to be completely frank.

"At the same time, the analyst must always keep in mind the fact that it is wholly natural and legitimate for the family physician to have a personal interest in and sense of responsibility for his patient, as well as a scientific interest in the progress of the analysis and a reasonable amount of sheer curiosity to boot . . ."

Withdrawal of EACA Favored In Intracranial Aneurysms

By MICHAEL HERRING
Medical Tribune Staff

ATLANTA—Antifibrinolytic medication in patients with recently ruptured intracranial aneurysms should be gradually withdrawn after 14 days due to the increasing likelihood of venous, arterial, and renal complications, according to a neurosurgeon at the University of Mississippi Medical Center.

Reporting on 92 neurosurgical patients who received preoperative doses of episilon-aminocaproic acid (EACA), Dr. Robert R. Smith, Associate Professor of Neurosurgery, told the Congress of Neurological Surgeons here that the drug unquestionably reduces rebleeding of aneurysms. It also "preserves the clot within the aneurysm until we can get it clipped at a safe interval after rupture," he told MEDICAL TRIBUNE.

However, while the drug is effective "in doing what we want it to do," Dr. Smith said in an interview, physicians should "use it correctly, and I wish they would monitor it closely, not use it too long, and watch for these [thrombotic] complications.

"It is our feeling at present, that if and when a complication is encountered, medication should be withdrawn over a three-day interval because such a patient is much more likely to have other complications as well," he told the Congress.

Withdrawal over a three-day period, halving the dose each day, seems to prevent the laboratory evidence of rebound and the withdrawal bleed, he added.

14-Day Delay

"Certain individuals seem to tolerate therapy poorly," he said. Others may be deficient in fibrinolytic enzymes to begin with, and be at higher risk of developing multiple complications. Modification of dosage and length of therapy may improve the overall benefit of EACA and other antifibrinolytic drugs in these cases, he indicated.

In the series of 92 patients, each received 12 to 48 gm per day of EACA, from one to 33 days with an average of 13 days, Dr. Smith reported. None were operated within 14 days of the original bleed—a dangerous period for the patient—and therapy in the majority of cases was continued until the aneurysm was surgically obliterated.

"Pulmonary emboli occurred at a frequency of some two to three times the expected rate," Dr. Smith reported. "Mortality with embolization was higher as well," causing the deaths of four out of six patients who threw emboli. This and other studies have shown that thrombi formed in the presence of EACA may be more resistant to lysis and more likely to propagate than those developing in untreated patients.

In addition, "while clinical evidence of pulmonary embolization occurred in only six patients, it is quite likely that other patients had deep vein clots and experienced pulmonary emboli," Dr. Smith said. "Approximately half of the asymptomatic patients studied [by phlebograms and pulmonary scans] showed evidence of pulmonary embolization or deep vein clots."

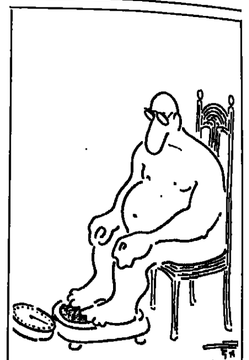
Six patients in the series developed uremia, Dr. Smith added, and two required renal dialysis. The other four responded to withdrawal of medication or reduction of dosage. EACA is also "strongly suspected" in the etiology of renal cortical necrosis such as found in these patients, who had no preexisting renal disease or hypotension, Dr. Smith said.

No Infarctions

Moreover, "major peripheral arterial occlusion was encountered in two individuals. Spontaneous occlusion of the femoral artery took place in a 49-year-old man with an anterior communicating aneurysm," he noted. The patient received a femoral thrombectomy and flow was restored.

Dr. Smith said he found no evidence of myocardial infarctions, and a lower than expected rate of hydrocephalus among the patients. However, of the patients who rebled from their aneurysms during the course of the study, four died, he told MEDICAL TRIBUNE. Two others died suddenly of unexplained causes (i.e., "treatment failures"), for a total of ten deaths in the series, Dr. Smith added.

"The average aneurysms which rebled did so after four days of antifibrinolytic therapy. However, the second day was by far the most common day for bleeding to occur and as a result adequate blood levels had not been reached in many of those who had rebled. The average thrombolic complication occurred after 14 days of EACA therapy and they were significantly increased in those patients treated for longer than 14 days," Dr. Smith reported.



Questions Raised on Cancer Immunotherapy

Continued from page 1

Division of Cancer Treatment, emphasized the theoretical potential of immunotherapy in his assessment of the modality but described "the potency of its specificity for cancer cells" as limited at the present time.

"The practical future of immunotherapy appears to lie in its role as part of a combined modality approach," he told an International Conference on Immunotherapy of Cancer, sponsored by the New York Academy of Sciences.

The patients most likely to benefit are those who have only small foci of tumor cells remaining after major surgical, radiotherapeutic, or chemotherapeutic ablation, Dr. Carter said. In his view, it is unlikely that immunotherapy alone will ever bolster host defenses sufficiently to reverse tumor growth in patients with advanced disease.

Reports from clinical trials of immunotherapy are proliferating—some 200 protocols are listed with the International Registry of Tumor Immunotherapy—and Dr. Carter commented at a news conference that publicity given to some reports may have raised what he described as "unrealistic expectations."

Citing data on the most widely tested agents or techniques, he offered the following evaluations:

• BCG has been employed in the largest number of trials, most often for malignant melanoma but also against the acute leukemias.

Intralesional BCG treatment in melanoma has achieved nodule regression in a good percentage of cases but patients with visceral lesions fail to respond, Dr. Carter said. In many instances, the therapy produces side effects ranging from fever and chills to localized abscesses and regional lymphadenitis.

A number of investigators are studying plural modalities for melanoma such as the combination of chemotherapy and BCG given by scarification or the use of BCG as an adjuvant in primary surgical resection of regional lymph node metastases. While reports have indicated longer periods of remission and survival time for the experimental groups, Dr. Carter pointed out that some of the studies were nonrandomized or lacked adequate controls.

Data that have thus far emerged from two major trials of BCG in acute lymphocytic leukemia seem to indicate no significant difference between controls and BCG-maintained patients in duration of remission induced by chemotherapy, he said.

In acute myelogenous leukemia, however, a combination of immuno- and chemotherapy has been observed by some investigators to achieve a median duration of remission longer than that seen in patients on maintenance chemotherapy alone.

One major problem in determining the efficacy of BCG therapy is the variability in the vaccine itself, according to Dr. Carter. Critical factors include viable cell count, ratio of living to dead microorganisms, and stability of fresh liquid preparations, not to mention dose level.

520 Combinations

He noted that there are presently five different BCG preparations, seven possible administration routes, two dosage levels, and two schedules in three possible sequences (before, after, concomitant) with surgery, radiation, or drug therapy.

This all adds up, Dr. Carter figures, to "520 potentially different trials for BCG in the single clinical setting of any given tumor at any given disease stage." As a result, he cautions against "making facile interpretations leading to broad conclusions" from single studies.

• A relatively new agent—methanol extraction residue of BCG (MER-BCG)—was described by Dr. Carter as a "powerful, nonspecific immunostimulant" that is being intensively evaluated and that is now considered an effective adjuvant for remission maintenance in acute myelogenous leukemia.

It has also been used to treat metastatic gastrointestinal carcinoma, and in a few patients has produced greater than 50% regression with associated improvement in symptoms. Side effects have been few and minor.

• Widespread clinical trials of heat-killed cells of Corynebacterium parvum are "just beginning" after years of preliminary studies, Dr. Carter said. One research group has reported significant prolongation of survival in patients with metastatic solid tumors on a regimen of C. parvum plus combination chemotherapy as compared to survival of similar patients treated by chemotherapy alone. Dr. Carter believes, however, that patient-selection factors make it necessary to interpret these data "cautiously."

• Active immunotherapy via vaccines is being studied in several centers. Dr. Carter described the results as difficult to evaluate because vaccines have often been given in combination with other types of immunotherapy.

• Passive immunotherapy based on administration of antitumor sera has produced "little evidence" of clinical effectiveness, he said. Although passive immunotherapy with lymphoid cells has been accomplished in animals, "the problem of rejection of transferred lymphocytes in man has not been solved" except where identical HLA matching of cells from siblings is possible.

• Adoptive immunotherapy is being attempted by three approaches: "nonspecific stimulation of lymphocytes with agents such as phytohemagglutinin or specific sensitization of lymphocytes with tumor cells in vitro; passive transfer of lymphocytes sensitized by transplantation of tumors; and administration of extracts of sensitized cells."

Dr. Carter said the first two approaches have produced individual tumor responses but in his opinion they have not been consistently effective.

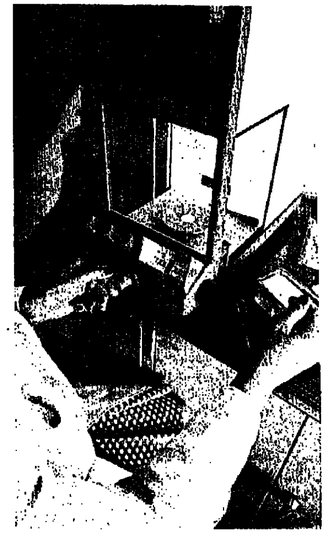
Information is still scarce, he concluded, about the third approach—transfer of informational molecules able to arouse a specific immune response in the recipient's immune system. Transfer factor and immune RNA are the substances most often investigated.

Findings have indicated that transfer factor can modify cellular immunity and is occasionally associated with tumor regression, Dr. Carter said. But he stressed the need for further knowledge about donor and recipient selection, quantitation and dosage, and characterization of transfer factor itself.

National Center Oversees Worker Safety in Turkey

SOME 100,000 WORKERS are killed in industrial accidents each year, and 1,500,000 more are permanently disabled, according to the International Labor Organization. Part of the problem is the escalating hazards from new technology. After World War II the number of chemical substances causing recorded occupational disease was about 50. Experts calculate that about 600,000 chemicals are now in daily use and many can produce harmful side effects. Historically, health and safety standards have been set for individual industrial groups, but the trend now appears to be toward integrated programs guided by special national centers. A center of this type has been established in Ankara, Turkey, with the cooperation of the I L O. Its program includes equipment and training courses for detecting and evaluating work dangers, assistance in the design of control devices, and supervision of safety standards for machines and protective equipment. Factory physicians, industrial hygienists, and nurses are among those who can attend the postgraduate and refresher courses also offered by the center.

Ms. E. Baysal, an expert from the center, fits a factory worker with a personal dust sampler.



Weighing filters for airborne dust samples.

Dr. D. Lostar evaluates the temperature, humidity, and air velocity at a factory.

Beds are available at the social security clinic for patients who have contracted occupational diseases. Here, Dr. E. Tongac examines a worker with lead poisoning.

More Physician Responses to Dr. Lasagna's Letter and to Dr. Sackler's Column

The response of physicians to Dr. Louis Lasagna's letter on the use of antibiotics in treating the secondary bacterial complications of the common cold continues, with letters in support of Dr. Lasagna's attitude running approximately 10 to one. "Most patients do not visit a doctor's office, and pay good money, for advice about uncomplicated coryza," wrote Dr. Lasagna, inviting physicians to describe what they do.

His letter, published in the same issue (Nov. 19) as the column by Dr. Sackler describing how the complications of President Ford's "common cold" were treated with an antibiotic, has drawn many thoughtful letters. We continue to publish them.
—The Editor

I appreciate your attempt to defend our profession, but I wonder whether your effort is worthwhile. I am a rural practitioner in internal medicine and I work to maintain a high standard of care. While I most certainly do prescribe antibiotics for selected upper respiratory infections, I evaluate each case individually. I do not use sputum cultures (as sarcastically suggested by Dr. Sackler) because they have been discredited. I do not believe, moreover, that fever, cough, rhinorrhea, nasal stuffiness, post-nasal drip, or earache, in themselves, indicate a bacterial infection or justify the usage of an antibiotic. If I find no evidence of pneumonia, strep throat or acute sinusitis, I will usually use, as my major criterion, the color and consistency of the sputum. Resistant cases or mitigating host factors such as age or intercurrent illness may affect my decision. In any case I ask the patient to "report in" in two or three days.

My choice of antibiotic is usually a tetracycline or erythromycin. In resistant or recurrent cases I may use ampicillin.

My opening comments on the worthwhileness of your crusade are prompted by my observation that many doctors *do*, indeed, prescribe antibiotics "at a spinal reflex level." Patients *do* come to the doctor with just fever, cough, and coryza, and often physicians *do* respond with an intramuscular injection of penicillin. Sometimes the therapy is IM penicillin followed by oral ampicillin; sometimes it's a single inadequate dose of penicillin, such as Bicillin C-R, 600,000 units.

I am heartened by your interest in this problem and hope that you will not be *dis*heartened by the responses you receive—this one included. I look forward very much to reading or hearing of the results of this informal survey.

DAVID J. MELTZ, M.D.
Newton, N.J.

I applaud the views of Doctor Lasagna, Doctor Sackler, and your editorial policy concerning the use of antibiotics for "the common cold." I deplore the know-it-all attitude of academic and bureaucratic physicians who never have to see 55 acutely ill children in one day as I did yesterday. However, in pediatrics at least, I believe that many of the patients that we see are no sicker than patients who never call. We see them because their parents are more anxious than those who remain at home. Some parents do have a great desire for the physician to "do something" even if nothing need be done. Although many of the children we do see are those with complications, another large group merely represents those whose parents are more anxious even though the degree of illness does not warrant therapy; and it is the essence of medicine to separate one from the other.

GILBERT L. FULD, M.D.
Keene, N.H.

I agree with Dr. Lasagna. It is too bad that so much criticism has been directed against the doctors in practice.

WILLIAM SIEGMANN, M.D.
Minneapolis, Minn.

In response Dr. Lasagna's letter to Dr. Sackler, I must say I know very few physicians, *if any*, who prescribe antibiotics for the "common cold." In my area of practice, and I suspect in many others, any type of URI is called a "cold" by patients . . . Many's the patient I have seen who comes in with a complaint of "cold", but is, rather, the whole gamut from a viral URI to pneumonia. *And*, I personally learned a long time ago that some rather benign-looking throats gave a positive culture for strep, and let us not forget the false *negative* cultures for beta strep. I quite agree that most patients do not come to the office for "common cold" treatment; if they did, we could not possibly treat them. There are not that many doctors or hours in the day.

EUGENE GUAZZO, M.D.
Mechanicsville, Md.

I support Dr. Lasagna's contention that the majority of patients I see suffering from "colds" are actually suffering from secondary bacterial complications and do indeed need an antibiotic. I see approximately 200 patients per week with a cross section of all types of problems and obviously during epidemics the percentage of people seeking help from complications of the "common cold" runs high.

Those who merely have simple coryza are given a nonantibiotic prescription. The doctor is absolutely correct in stating that the majority of patients do not come to the doctor for the simple uncomplicated coryza.

THOMAS C. PRINCE, JR., M.D.
Knoxville, Tenn.

Congratulations to Dr. Lasagna on his recent comment on colds and antibiotics. I have a rather large practice in Glendale, California, where I have practiced for 20 years. Throughout these years, one of the greatest acts that I take personal pride in is that in the treatment of a cold with or without complications of a serious nature, I have always answered the question "When do you want to see me again, Doc?" with "Only if you don't improve will I want you to return in one or two days."

My personal experience has been that 95-98% get well after the first visit which usually includes an antibiotic and complementary treatment, particularly with infants with their rhinorrhea that would become purulent in a couple of days without the antibiotic.

My patients cannot afford three main things: 1. a needless return visit for a cold; 2. cultures and antibiotic sensitivity testing; and 3. the waiting, suffering and disability until the results from such testing returns from the laboratory.

Results are what count and the percentages are high on excellent results using antibiotics without abuse. The patient expects and deserves to get the best treatment available. It's too bad it takes a national figure to finally bring this out.

When President Nixon was hospitalized for his pneumonia, I could not understand why my patients should now have their pneumonia treated at home because certain groups drawing up criteria were in fact drawing up two sets of recipe books for the same condition. One for notoriety and public figures and one for the common folk. This is the same with the common cold. President Ford gets a cold and all means are used to shorten the misery from it . . . . and so it should be, after all he is human . . . . but so should the rest of the humans receive the same treatment.

Dr. Lasagna, I am with you in the interest of saving the patient time, money, misery and suffering by employing the most sensible means to treat the most evasive disease entity we have.

E. W. ARELLANO, M.D.
Glendale, Calif.

President Ford was treated for his cold as he should have been, thanks to Dr. Lukash.

There is still a science of medicine and an art of medicine and there is great reliance by patients and practicing doctors that antibiotics do help the common cold.

Your article relating to President Ford was excellent.

ELVIN E. KEETON, M.D.
Grand Prairie, Tex.

I agree with Dr. Lasagna completely. I have tried following the admonitions of the ex-egg heads in high places with respect to non-treatment of colds. I find that almost universally I see the patient again in almost four or five or ten days much worse off and have to go the antibiotic route in order to treat them adequately.

These idealizing research physicians who live far and above the common everyday man really don't know what it is all about. I guess these theorists really have to do something to justify their existence, and criticism of the practical is the easiest way for them to retain and maintain their power and their glory.

DAVID L. MESSENGER, M.D.
Placentia, Calif.

I wholeheartedly agree with the opinion of Dr. Louis Lasagna. Thank you so much for your article concerning "The President's Common Cold."

In general, most patients come in with complications of the upper respiratory common cold only after a week or two of self medication. These patients then generally tend to demand and also tend to get antibiotics.

In regards to those who come in early with an upper respiratory infection and are given antibiotics, in my practice this mode of therapy is followed because of previous experience. That is, the patients know that invariably they have debilitating and complicating problems of the common cold and by experience they know they get well a lot faster with the use of antibiotics.

Again, I believe that on a whole, the doctors that I know practice in the same manner.

JOHN H. PUTMAN, M.D.
Redondo Beach, Calif.

Dr. Lasagna Writes on Colds and Antibiotics

March 27, 1974

Dear Arthur:

One of the most constantly raised points in the current discussion about overprescribing of drugs is the alleged prescribing at a spinal reflex level of antibiotics for "the common cold." It is repeatedly said that in surveys of doctors in practice, a very high percentage of patients who come to the doctor's office for "the common cold" receive an antibiotic.

On the face of it, this seems reprehensible. On reflection, however, it occurs to me that most patients do not visit a doctor's office, and pay good money, for advice about uncomplicated coryza. I suspect, instead, that most patients with upper respiratory complaints go to see doctors suffering from a combination of cough, stuffed nose, post-nasal drip, swollen glands in the neck, earache, etc.—in other words, from secondary bacterial complications of the common cold. If this is the case, then the prescribing of an antibiotic is not wrong; rather, the question is only: what antibiotic would be best?

I ask that you print this letter in Medical Tribune to solicit from your readers some facts bearing on the statements I have just made. If I am wrong, then the doctors of this country deserve the severe criticism they are receiving from many quarters at present. If I am right, then the doctors are practicing good medicine, and it is the critics who deserve disapproval.

Louis Lasagna, M.D.

Reprinted from MEDICAL TRIBUNE, *Nov. 19, at request of Dr. A. M. Sackler*

In regard to your recent article on prescribing for the common cold, I would like to say that I heartily concur in the treatment that was given. I think those who do not recognize secondary bacterial complications of the common cold and treat accordingly do far more harm than those who allegedly overuse antibiotics.

The regimen was excellent and one that I would like to think I would have done if I were in the same situation.

JOHN M. CHURCH, M.D.
Fort Worth, Tex.

I couldn't be more in agreement with the letter that Dr. Louis Lasagna wrote.

I have been in private practice for 30 years, and it seems to me that I have treated kids for many years not so much for the so-called common cold, *but* for the "not common" cold, as mothers bring them in after most have been sick for five to ten days (diagnostic semantics).

In my observation, the majority of children who get antibiotics do better than those who do not receive antibiotics. *Unless* I know that it is truly viral at its onset, I usually will give antibiotics without a culture especially if the condition is bronchitic in nature, or if there is a purulent discharge and/or tonsillitis or lymphadenopathy. All sore throats are cultured.

Often, people who have been to other doctors who give only nose drops and decongestants come to me because they are worse, and, of course, they do not tell the first doctor that they have gone elsewhere for treatment.

It is markedly different to practice in an ivory tower than to practice on the front line. There needs to be more "pastoral" medicine.

N. G. RASMUSSEN, M.D.
Dodgeville, Wis.

I am in accord with Dr. Lasagna's statement as printed in the MEDICAL TRIBUNE with notations by Dr. Arthur M. Sackler, that the colds I treat in my office do indeed have secondary bacterial complications, and I do treat with antibiotics. When parents bring a child to my office, they want the child helped and antibiotics are the answer.

ZELDA E. HEINBY, M.D.
Dayton, O.

Dr. Lasagna is correct! Not many people come to a physician for treatment of the common cold. In our E.R., the patients who do come for treatment of their common (?) cold almost invariably have additional symptoms such as otitis, pharyngitis, bronchitis, severe cough, etc. When they have these symptoms, then they need and receive antibiotics.

As you well know, when the Federal Government regulates then it soon dictates, and the quality of care and services deteriorates. This happens to anything or any service the government tries to regulate.

ALBERT G. ROADS, M.D.
Franklin, Pa.

The majority of my patients with respiratory infections do not receive antibiotics; only those with complications.

R. MEL PERRY, M.D.
Ventura, Calif.

Computer Aids Care

With use of new computer, health personnel who treat members of the 12,000-member Papago Indian tribe in Arizona have access to complete health records for all persons seen during clinic or home visits.

Use of Stapler Simplifies Abdominal Hysterectomy

Medical Tribune World Service

AMSTERDAM—A simplified technique of abdominal hysterectomy reported here by a U.S. surgeon brought subsequent morbidity down almost to zero in a series of 80 patients.

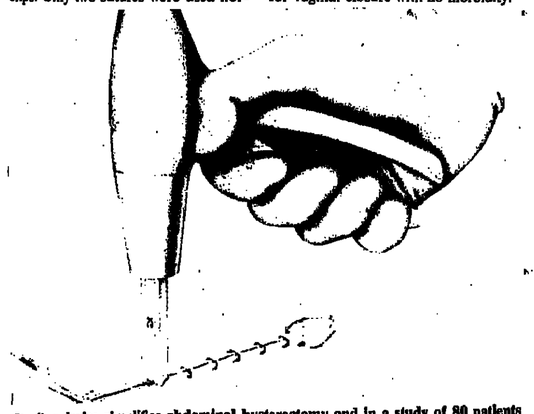
Average in hospital stay was reduced by one-third, and the reduced use of catheterization, and absence of wound infection or pulmonary embolism, led to lower hospital bills, Dr. Joseph Lee Sedwitz told the 9th European Federation Congress of the International College of Surgeons.

Discussing the technique, Dr. Sedwitz, of Wake Memorial Hospital, East Wake Branch, Raleigh, N. Carolina, emphasized that self-retaining retractors, packs and catheters were eliminated wherever possible after use of stapling instruments or metal hemoclips. Only two sutures were used normally, and the procedure took only from 30-60 minutes.

Vibramycin (200 mg) was given IV at time of surgery, and 100 mg orally for two days. There were no deaths or wound infections, and complications were limited to one patient who ran a temperature of 101°F associated with a pelvic hematoma. This was drained by the vaginal approach.

Retained Staples

Dr. Sedwitz noted, however, that four patients had retained vaginal cuff staples which had to be removed under local anesthesia. One patient insisted on general anesthesia, and Dr. Sedwitz said such staples would seem to be inadvisable in emotionally unstable persons. In later experience, he and his colleagues used 4-5 medium hemoclips for vaginal closure with no morbidity.



Stapling device simplifies abdominal hysterectomy and in a study of 80 patients brought postoperative morbidity down almost to zero. Technique also reduced hospital stay by one-third, lowered hospital bills, reduced the need for catheterization. Surgeon reported absence of wound infection.

Self-Given Heparin Treats Phlebitis Safely

Continued from page 1

study to prove this mode of therapy beneficial or necessary in preventing either local or pulmonary complications." In fact, he added, "there is no established therapeutic protocol for acute and subacute thrombophlebitis."

He and his collaborators undertook "a cautious evaluation" of ambulatory heparin treatment as a result of an increasing number of referrals, rising costs, and the limited availability of hospital beds, Dr. Stillman observed. "The general course of these patients has been so rewarding—and complications so few—that this protocol was gradually expanded to include all but the most seriously ill."

He stressed that the treatment is confined to acute and subacute cases. "Chronic venous insufficiency and chronic thrombophlebitis have shown uniform resistance to resolution despite the treatment method."

The patients in the decade-long study ranged in age from 16 to 92, with the average in the 50- to 60-year-old group. Most (77%) were women.

In the treatment protocol, each patient receives both verbal and written instructions. The starting heparin dose is 20,000 units self-administered subcutaneously into the abdominal fat pad. If the patient is too fearful or frail to administer the injection, a member of the family or a visiting nurse does it, Dr. Stillman said. Whole blood clotting times are performed weekly until stable, then monthly. Heparin dosage is tapered when there is a clotting time over 20 minutes and symptomatic improvement, or a clotting time over 30 min.

Mile-a-Day Walk

Mechanical therapy, Dr. Stillman said, includes elevation of the foot while sleeping, walking at least one mile a day, if possible, hydrotherapy (or warm bath daily) and the use of elastic stockings or elastic wraps.

If the patient remains asymptomatic and clotting time remains stabilized on a tapered dosage, heparin is discontinued and anticoagulation maintained by aspirin 1.2 to 2.4 gm daily, the physician declared.

Although 73% of the patients in the overall series are free of recurrent disease, Dr. Stillman stressed: "Of course, the possibility of recurrence increases with time, and it is possible that all patients will suffer some form of recurrent disease if followed for a long enough period."

The complication rate has been small, with only seven cases of documented pulmonary emboli, none fatal, and nine cases of abnormal bleeding.

In discussion, Dr. Stillman observed: "Although this is not a controlled study, the small recurrence rate and minimal frequency of complications indicate it to be an effective and safe therapeutic modality. There is no question in this group of patients that symptomatic improvement has been achieved. The saving in hospitalization costs is enormous. . . Longer term follow-up of these patients will help confirm that, as we suspect, progressive chronic venous insufficiency is actually prevented."

Tested by time and experience in the treatment of MBD

1962

"...a considerable decrease of hyperactivity...."[1]
Knobel, 1962

Over a decade of controlled studies and clinical experience has shown the effectiveness of Ritalin in reducing the hyperactivity,[1-3] distractibility,[1,4,5] and disorganized behavior[1-8] in the MBD child.

By lessening the effects of motor and attentional disorders, Ritalin can help the MBD child to better focus his attention on meaningful stimuli and thus can often improve cognition and promote learning.[6,9]

And side effects—insomnia and appetite loss—with Ritalin have occurred less frequently than with dextroamphetamine.[10,11]

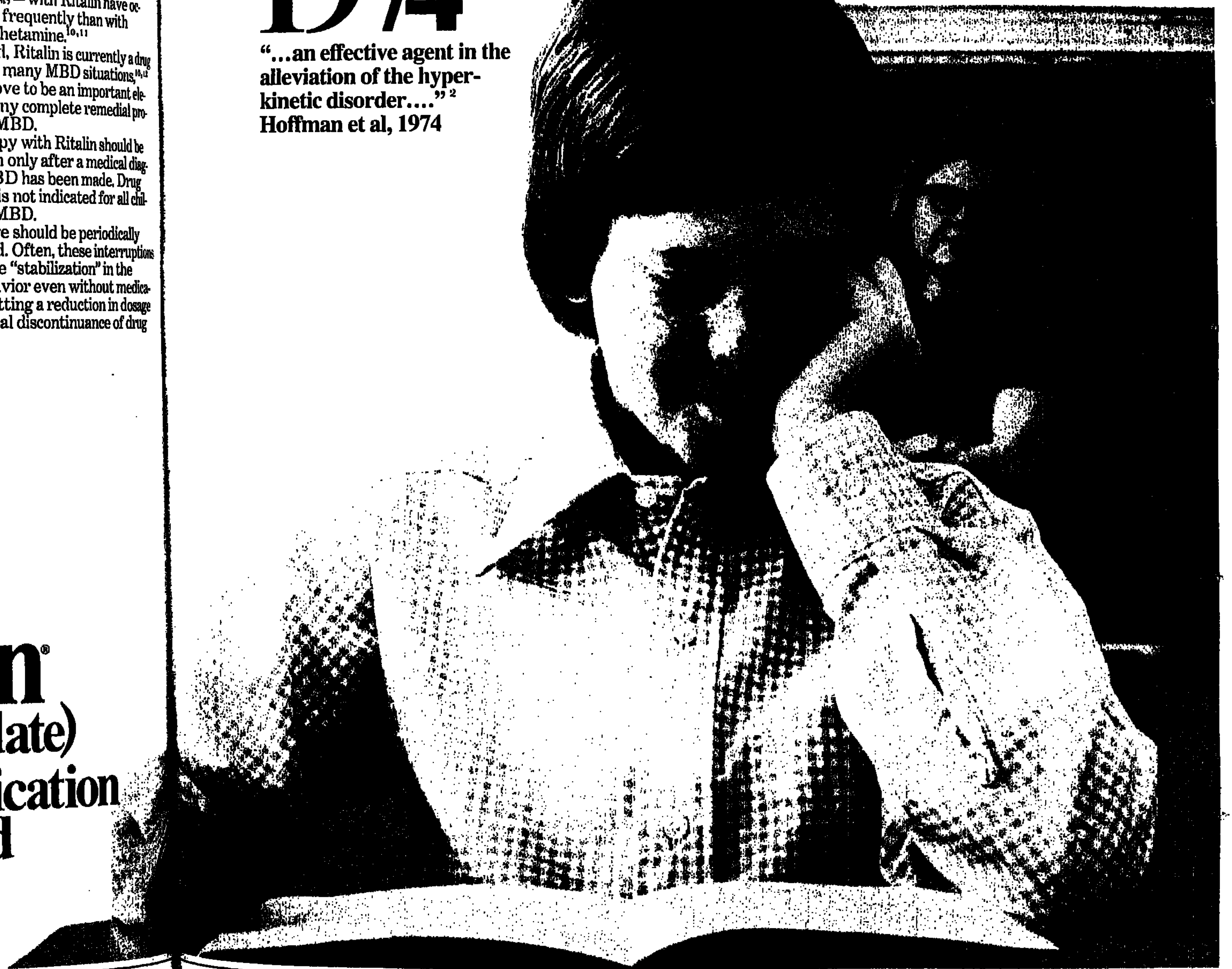
Indeed, Ritalin is currently a drug of choice in many MBD situations[11,12] and can prove to be an important element in many complete remedial programs for MBD.

Therapy with Ritalin should be undertaken only after a medical diagnosis of MBD has been made. Drug treatment is not indicated for all children with MBD.

Dosage should be periodically interrupted. Often, these interruptions reveal some "stabilization" in the child's behavior even without medication, permitting a reduction in dosage and eventual discontinuance of drug therapy.

1974

"...an effective agent in the alleviation of the hyperkinetic disorder...."[2]
Hoffman et al, 1974



Ritalin®
(methylphenidate)
Only when medication is indicated

Ritalin® hydrochloride ©
(methylphenidate hydrochloride)

TABLETS

INDICATION
Minimal Brain Dysfunction in Children—as adjunctive therapy to other remedial measures (psychological, educational, social)

Special Diagnostic Considerations
Specific etiology of Minimal Brain Dysfunction (MBD) is unknown, and there is no single diagnostic test. Adequate diagnosis requires the use not only of medical but of special psychological, educational, and social resources.
Characteristics commonly reported include: chronic history of short attention span, distractibility, emotional lability, impulsivity, and moderate to severe hyperactivity; minor neurological signs and abnormal EEG. Learning may or may not be impaired. The diagnosis of MBD must be based upon a complete history and evaluation of the child and not solely on the presence of one or more of these characteristics.
Drug treatment is not indicated for all children with MBD. Stimulants are not intended for use in the child who exhibits symptoms secondary to environmental factors and/or primary psychiatric disorders, including psychosis. Appropriate educational placement is essential and psychosocial intervention is generally necessary. When remedial measures alone are insufficient, the decision to prescribe stimulant medication will depend upon the physician's assessment of the chronicity and severity of the child's symptoms.

CONTRAINDICATIONS
Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug and in patients with glaucoma.

WARNINGS
Ritalin should not be used in children under six years, since safety and efficacy in this age group have not been established.
Sufficient data on safety and efficacy of long-term use of Ritalin in children with minimal brain dysfunction are not yet available. Although a causal relationship has not been established, suppression of growth (*ie*, weight gain and/or height) has been reported with long-term use of stimulants in children. Therefore, children requiring long-term therapy should be carefully monitored.
Ritalin should not be used for severe depression of either exogenous or endogenous origin or for the prevention of normal fatigue states.
Ritalin may lower the convulsive threshold in patients with or without prior seizures; with or without prior EEG abnormalities, even in absence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued.
Use cautiously in patients with hypertension. Blood pressure should be monitored at appropriate intervals in all patients taking Ritalin, especially those with hypertension.

Drug Interactions
Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.

Usage in Pregnancy
Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

> **Drug Dependence**
> Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.
> Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

[illegible]IONS
[illegible] with an element of agitation may react [illegible] discontinue therapy if necessary. [illegible], differential, and platelet counts [illegible] during prolonged therapy.

[illegible] REACTIONS
[illegible] and insomnia are the most common [illegible] reactions but are usually controlled by [illegible] dosage and omitting the drug in the [illegible] or evening. Other reactions include: [illegible] (including skin rash, urticaria, [illegible], exfoliative dermatitis, erythema [illegible] with histopathological findings of [illegible] vasculitis, and thrombocytopenic [illegible] anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood [illegible] and pulse changes, both up and down; [illegible] angina; cardiac arrhythmia; abdominal pain; weight loss during prolonged [illegible]. Toxic psychosis has been reported. Although a definite causal relationship has not been [illegible], the following have been reported [illegible] taking this drug: leukopenia and/or [illegible] a few instances of scalp hair loss. [illegible] loss of appetite, abdominal pain, [illegible] during prolonged therapy, insomnia, and tachycardia may occur more frequently; however, any of the other adverse reactions listed above may also occur.

DOSAGE AND ADMINISTRATION
Children with Minimal Brain Dysfunction (6 years and over)
Start with small doses (*eg*, 5 mg before breakfast and lunch) with gradual increments of 5 to 10 mg weekly. Daily dosage above 60 mg is not recommended. If improvement is not observed after appropriate dosage adjustment over a one-month period, the drug should be discontinued.
If paradoxical aggravation of symptoms or other adverse effects occur, reduce dosage, or, if necessary, discontinue the drug.
Ritalin should be periodically discontinued to assess the child's condition. Improvement may be sustained when the drug is either temporarily or permanently discontinued.
Drug treatment should not and need not be indefinite and usually may be discontinued after puberty.

HOW SUPPLIED
Tablets, 20 mg (peach, scored); bottles of 100 and 1000.
Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Accu-pak® blister units of 100.
Tablets, 5 mg (pale yellow); bottles of 100, 500, and 1000.

Consult complete product literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

References:
1. Knobel M: Psychopharmacology for the hyperkinetic child, *Arch Gen Psychiatry* 6:198-202, 1962. 2. Hoffman SP, Engelhardt DM, Margolis RA, et al: Response to methylphenidate in low socio economic hyperactive children. *Arch Gen Psychiatry* 30:354-359, 1974. 3. Sprague RL, Barnes KR, Werry JS: Methylphenidate and thioridazine: Learning, reaction time, activity, and classroom behavior in disturbed children. *Am J Orthopsychiatry* 40:615-628, 1970. 4. Knights RM, Hinton GG: The effects of methylphenidate (Ritalin) on the motor skills and behavior of children with learning problems. *J Nerv Ment Dis* 148:643-653, 1969. 5. Seger EY, Hallum G: Methylphenidate in children with minimal brain dysfunction: Effects on attention span, visual-motor skills, and behavior. *Curr Ther Res* 16:635-641, 1974. 6. Conners CK, Eisenberg L: The effects of methylphenidate on symptomatology and learning in disturbed children. *Am J Psychiatry* 120:458-464, 1963. 7. Creager RO, Van Riper C: The effect of methylphenidate on the verbal productivity of children with cerebral dysfunction. *J Speech Hear Res* 10:623-628, 1967. 8. Comly HH: Cerebral stimulants for children with learning disorders. *J Learning Disabil* 4:484-490, 1971. 9. Mackay MC, Beck L, Taylor R: Methylphenidate for adolescents with minimal brain dysfunction. *NY State J Med* 73:550-554, 1973. 10. Paine RS: Syndromes of "minimal cerebral damage." *Pediatr Clin North Am* 15:779-800, 1968. 11. Conners CK: Symposium: Behavior modification by drugs: II. Psychological effects of stimulant drugs in children with minimal brain dysfunction. *Pediatrics* 49:702-708, 1972. 12. Charlton MH: Symposium: Minimal brain dysfunction and the hyperkinetic child: Clinical aspects. *NY State J Med* 16:2058-2060, 1972.

2/1033 17

CIBA

British Health Service Seen Emerging from Year of Strife

Continued from page 1

the juniors for overtime payment after 40 hours a week, and the desire of the consultants to retain "pay beds" for private patients in government hospitals. At stake was the queston of the extent to which individual incentive and reward can coexist with the concept of a national health service.

The crisis in the NHS, which has been simmering for the past 18 months, came to an explosive head in late November when junior doctors rejected an offer of overtime payments of little more than a dollar an hour. In protest, they started working from 9 AM to 5 PM, which meant that casualty departments in a large number of hospitals had to close to all but emergency cases.

Consultants Incensed

At the same time, the consultants, incensed by the Labour Government's decision to bring in legislation phasing out pay beds, threatened to resign *en masse* and also started, in many instances, to work only the contracted 40 hours a week.

As a result of these combined actions, patients found themselves on hospital bed waiting lists that, long to begin with, grew even longer. Some hospitals restricted care to pediatric patients, expectant mothers, seriously ill patients and emergency cases. Some smaller institutions virtually shut down, transferring patients elsewhere or sending them home. Deaths directly attributable to these disruptions were reported.

Mrs. Castle at first decided to ride out the young doctors' challenge because of the government's pay policy, which last year limited wage increases to a maximum of $12 a week in an effort to beat inflation, currently running at 25% per annum. She maintained that the residents could not be paid more.

In reply, the juniors accused her of breaking a pledge she made one year ago when she persuaded them not to strike by promising them reasonable rates for overtime.

Anger Underestimated

To many observers, it was clear that Mrs. Castle and the government underestimated the extent of the residents' anger and discontent. Despite her appeals for them to think of their patients and despite in most cases a not very sympathetic press, the majority of residents continued their action.

More important, they challenged Mrs. Castle's financial figures, with apparent success, because she is now admitting that there might be more money available in the NHS kitty that they can have without breaking the pay code.

Since most residents appear basically sympathetic to the NHS concept, wanting only fair compensation, Mrs. Castle seemed to have found a face-saving solution to their challenge.

However, it did not look as though the battle with the consultants could be resolved so easily. Their quarrel is more complex because it involves not only conditions of work but also their deep distrust of Mrs. Castle and the Labour Government in general.

When the health service was introduced in 1948, to entice doctors into its hospital practice the government offered them contracts to work either full-time or nine-tenths. Many took the part-time contract, not wanting to become full-time servants of the state. In typical British compromise fashion, the system has worked well—at least in the consultants' opinion, with most of their private practice being carried out utilizing pay beds in the governmental hospitals.

Now the government has decided that these pay beds (which only amount to 1% of the total number of beds) must go. Mrs. Castle sees them as a "canker of commercialism at the heart of the National Health Service" and cites reports of queue-jumping for operations in state hospitals by those able to pay for private treatment.

The consultants reply that the abolition of pay beds will do nothing to reduce the waiting time for operations (up to two years in some specialities) and that the government is pursuing this policy for doctrinaire reasons, in order to make them full-time state employees and thus at its mercy, not only over conditions of pay but also over conditions governing the practice of medicine.

Abolish Pay Beds?

Mrs. Castle has protested that she does not want to abolish private practice, only pay beds. However, as many observers have pointed out, without hospital beds for private patients, private practice becomes meaningless. Private clinics are a dubious alternative, since they are relatively few and the costs of building them are increasing.

Even so, the consultants might have reluctantly given in on the question of pay beds had not Mrs. Castle announced the government's intention to review the licensing of private hospitals. It seemed clear that in addition to wanting private practice out of NHS hospitals she did not intend to allow a strongly competitive private sector to develop. This to the consultants was the final proof that under any Labour Government the days of private practice are numbered.

They have been furthered in this belief by the fact that all through the dispute, Mrs. Castle was supported by officials of the unions whose members work as porters, cleaners and kitchen staff in hospitals. The unions have increased the consultants' fears, to say nothing of their anger, not only by demanding the banning of all private practice inside and outside the state hospitals, but also by provocatively calling upon their members not to provide services for such patients anywhere now and in the future.

In the words of one union official, "The consultants went berserk."

With Mrs. Castle and the consultants locked in a very personal and bitter combat, the Prime Minister, Mr. Harold Wilson, agreed to set up a Royal Commission to examine the whole structure of the National Health Service. Such commissions consist of people from all spheres of life who may sit for two to three years before producing a comprehensive report which might or might not be acted upon. To the cynics, the commission is seen as a way of shelving a difficult problem, since most decisions on any action to be taken can be deferred until the commission reports.

However, the consultants are not opposed to this plan and are demanding that the question of pay beds be referred to the commission while in the meantime being allowed to continue. They obviously hope that by the time the commission reports, the Labour Government will be out of office and that in this way pay beds will survive.

Still, Mrs. Castle maintained that the legislation to phase out the beds must go through Parliament within the next year. And it is on this point that the very latest battle was being fought, with the consultants still threatening to resign and Mrs. Castle declaring that they are bluffing.

Reorganization a Failure

Finding a solution to these quarrels has not been helped by the fact that since April, 1974, the health service has been undergoing a vast administrative reorganization, conceived by the previous Conservative Government. The reorganization has been widely judged a disastrous and costly failure. It has added to the doctors' bitterness by increasing the number of administrators running the service whom the doctors see as "sitting on our backs," making their jobs and consequently their relationships with their patients more difficult.

If the consultants see themselves as harassed by officialdom, they also are upset by the image that the public has of them. No matter how much they try to explain in the press and on television that they are fighting for freedom—not simply to practice private medicine but more importantly for the public's right to have it—they are seen by many people as "money grabbers."

The press in particular has been unsympathetic to their cause, with comments such as this from the *London Guardian*: "For all the doctors' high-sounding protestations about clinical freedom, the dispute is really about property and the income and privileges which flow from it."

Misunderstood and, they suspect, increasingly unloved, the consultants have been looking with mounting envy at their family doctor colleagues, who in the UK do not engage in hospital practice. They have thus been outside the dispute and have, on the whole, kept a very low profile, making sympathetic noises but refusing to get drawn into the conflict.

Since they earn more than the consultants while, for the most part, working fewer hours, general practitioners realize that they are doing very nicely. This is reflected in the decision of more and more doctors to elect for general practice on qualifying, not only because three years out of medical school they can be earning as much as a consultant, but also because they work as independent contractors to the state, and are still to a large extent their own bosses.

The consultants warn that once the Labour Government has made them full-time state employees, it will turn its attention to the family doctors. But for the most part, the warning is falling on deaf ears. In the general practitioner sector of the medical profession in Britain there is comparative peace—at least for the time being.

Ballet for Mastectomy Patients

Ballet therapy classes with Diana Welch, artist-in-residence at the University of Santa Clara in California, help mastectomy patients regain fuller use of arms, as well as self-esteem. The year-old program began when Ms. Welch learned that a student's mother was having trouble adjusting to the loss of her breast. Classes have won endorsement from doctors, therapists, and the ACS.

SIDS Moms Have Trouble Conceiving Another Child

Medical Tribune Report

BOSTON—More than 60% of 32 mothers who lost babies through the sudden infant death syndrome (SIDS) had trouble conceiving another child during the period of acute grief following the death of their infant, according to Drs. Frederick Mandell and Lawrence C. Wolfe, of Childrens Hospital Medical Center.

SIDS mothers who quickly decided to have a replacement child showed more than three times the normal rate (10%) of fertility and more than twice the normal rate (12%-15%) of miscarriages in the year following the deaths of their infants. None of the mothers had had previous miscarriages, fertility problems, or other pregnancy complications.

Tribune Economic Analysis

Deflation Without Depression

BY ELIOT JANEWAY
Consulting Economist

Life was much simpler during the last Depression than it is in this crisis. Everyone sat out the Depression waiting for costs to shrink more than incomes. Deflation was the dominant trend; costs and incomes fell together until both hit bottom.

So painful was the deflation brought on by the Depression that it made inflation not only respectable but desirable. One of President Roosevelt's most effective ploys at the outset of his first term was to call off the deliberations of the World Economic Conference. He justified this brash act of nationalism on the grounds that he had been elected President of the United States with a mandate to raise prices inside the United States—not to engage in international talkfests.

The Problem Today

No national figure today would dream of advocating higher prices. Nor would any likely political survivor advise waiting for costs to fall by themselves.

The problem today is to break the vicious circle of costs inflating and incomes deflating before it breaks the backbone of resistance to the threatening depression. The reversal of the income trend signals a dangerous inability to carry the burden of continued cost inflation. Incomes are not likely to recover their lost ground against costs.

The only alternative to getting incomes up is to get costs down, and to get them down fast. The trick is to target a universal cost that is hurting everyone. Oil fills the bill; getting its world price down fast is the way to reverse the trend.

Ask Janeway

I have $100,000 invested in a mutual fund. I'm only receiving $7,500 a year (net). How can I increase my income in a safe way?

Dr. from Nebraska

You would appear to be overconcentrated in the operation of one management, even if the securities markets were not subject to crisis stresses. The simplest way to increase your income, while decreasing any risk of the losses you cannot afford, is to buy a certificate of deposit. With $100,000 you can. You can get over 12% on it, thus increasing your income by 46.6%.

Send your questions on finances, investments, taxes to Janeway, MEDICAL TRIBUNE, *880 Third Avenue, New York, N.Y. 10022.*

Bio Clock Manipulation Seen Longevity Hope

Continued from page 3

already used as food preservatives, with FDA approval, he pointed out.

Moreover, to reduce the normal eight hours of sleep by one-half hour a night, he said, would effectively add more than two years to "life expectancy," the equivalent of living in a world "where cancer deaths have been totally eliminated."

On the other hand, Dr. Hayflick challenged the dubious achievement of modern medicine, which has managed to nurture "unprecedented numbers of disabled and indigent old people who have survived infectious diseases, but who will not survive old age.

New Ethical System

"A new ethical system must surely emerge regarding heroic measures to prolong nonproductive or vegetative life," he added. "Under these circumstances, death is postponed, but not aging!"

He also noted that in every animal species except man, "there is no survival value in living beyond the plateau of reproduction and top physical condition." He therefore suggested that "the goal of gerontologic research in the future should be to understand the biologic basis of aging in order to extend the number of vigorous and productive years and to reduce the time spent in senility and the infirmities of old age."

He added, however, that the possibility of achieving such a goal by the year 2025 is again remote because of the present allocation of resources. "While we spend $2 per person per year on cancer, and $1 per person per year on heart diseases, we spend something like 3¢ per person per year on gerontologic research," he said.

One Man . . . and Medicine

ARTHUR M. SACKLER, M.D.
International Publisher, Medical Tribune

Character Assassination

Part I

JOE MCCARTHY had no monopoly on character assassination. This abomination goes back to man's earliest recorded history and reaches to our very day. It is not a technique restricted only to fascists on the right, or radicals of the far left. Of late it has been practiced by moderates, those of the center, and by liberals, more frequently than by those who have been labeled as reactionaries, crypto-fascists or fascists.

Back to earliest recorded history, you say?

Yes.

Judeo-Christian Tradition

The abomination of character assassination was considered so dangerous that in the fundaments of the Judeo-Christian tradition upon which so much of western ethics and morality are based, its essential elements are repeatedly denounced.

After Genesis comes Exodus. In Exodus the *Bible* says that God spoke to Moses. He gave him the Ten Commandments. It is remarkable that three of the ten commandments are applicable to character assassination. These are:

"Thou shalt not kill."

"Thou shalt not bear false witness against thy neighbor."

"Thou shalt not covet thy neighbor's house; thou shalt not covet thy neighbor's wife, nor his manservant, nor his maidservant, nor his ox, nor his ass, nor anything that is thy neighbor's."

Character assassination "kills." Character assassination breaks the injunction against bearing false witness. Character assassination covets not just anything that is your neighbor's, but something that is most important to him—his good name and reputation.

What do we find today?

Attacks on Physicians

The character of science and scientists is being repeatedly and falsely assassinated. The character of doctors and their procedures, of their drugs and the companies that make them, are being repeatedly and too often falsely assassinated.

There is no question that science, that biomedical researchers, practicing physicians, the makers of medicines and all who have anything to do with life and death, with health and suffering—all have a critical responsibility. Their social responsibility calls for the highest order of probity; a similar high order of probity should be applicable to those who wrap themselves in the mantle of righteousness as they criticize others.

Falsified Data

We have said before that to falsify data is worse than murder not only because acts of violence are usually impulsive and falsification is so often premeditated, but also because scientific fraud is a crime both against individuals and against society—in fact, against the very basis upon which our society rests. It is as great a crime to engage in character assassination as to pervert data or facts for personal or corporate profit. There is the motive of personal profit in too much of the character assassination that goes on—personal profit in visibility or publicity, in "kudos" or prestige, in fund raising and even government grants.

You may say, "On what do you base these charges?"

Perhaps a few examples will point to what is happening.

Character Assassination of Scientists

One of the most eminent scientists of our day, the man whom Nobel laureate James D. Watson referred to as "the greatest of all chemists," is Professor Linus Pauling. Pauling has twice been honored as Nobel laureate and most recently was awarded the National Medal of Science. Nonetheless, his honest convictions growing out of his meticulous and continuing reviews, studies and analyses of the literature and data on ascorbic acid as it relates to respiratory infections and to other conditions such as malignancy, have subjected him to character assassination.

This pernicious action has taken place in the *Journal of the American Medical Association* (an impermissible ad hominem attack by Jukes, *JAMA*, Aug. 11, 1975) and by individuals in government agencies (who pooh-pooh him publicly without having one-tenth or one-hundreth the knowledge or competence of a Pauling), despite the fact that many of them follow his advice privately. I have also found similarly ill-founded and unfounded attacks, lifted-eyebrows and questioning of his competence by some internists and other physicians I have met.

The Patronizing Manner

The personal satisfaction of acting in a patronizing manner or "superior" to a great man neither diminishes the man's greatness nor raises the stature of the critic. It may profit some egos, but it does not profit patients or science. In not a single instance, that I have confronted personally, have I been able to elicit an acknowledgment that the individual attacking Pauling's concepts had actually either read his arguments, reviewed his analysis *in extenso* or, for that matter, seen the original publications upon which Pauling bases his deductions.

Some time ago another physician, Dr. Saul Krugman, acting in the best of faith in his studies on hepatitis B vaccine, for which he won an award, was subjected to the most vicious personal attack by those claiming the right to represent the best interests of mentally retarded sick children.

These are two of the most conspicuous recent cases of the abomination of the character assassination of scientists.

To Be Continued

EPIGRAMS—Clinical and Otherwise

From birth to age eighteen, a girl needs good parents. From eighteen to thirty-five, she needs good looks. From thirty five to fifty five, she needs a good personality. From fifty-five on, she needs good cash.
Sophie Tucker, at age 69,
(1884-1966)

3 Diagnostic Tests Held of Little Value In Pancreatic Ills

Medical Tribune Report

LAS VEGAS, NEV.—Three tests commonly used to aid in the diagnosis of pancreatic disease proved to be "of little value" in a retrospective study reported here by Dr. James W. Manier, of the University of Wisconsin School of Medicine.

Pancreatic scintiscans, abdominal angiograms, and fecal fat measurements failed to yield conclusive or specific information, the investigator told the American College of Gastroenterology.

Dr. Manier, Chief of Gastroenterology at the Marshfield Clinic, evaluated the usefulness of 10 diagnostic tests by examining the records of 216 patients with histologically proven pancreatic cancer and 219 other patients who had had a tentative diagnosis of pancreatitis and who had shown at least one abnormal pancreatic test result. Test findings were then correlated with chart diagnosis.

Results Unreliable

Only two of 59 pancreatic scintiscans had been specific enough for a clinical diagnosis, Dr. Manier said. Among 18 scans interpreted as normal, one was that of a patient with carcinoma and five were of patients shown to have pancreatitis. The 13 scans in the "nonvisualization" category included those from seven patients with carcinoma and two with pancreatitis.

Selective abdominal angiograms also correlated poorly with established diagnoses, he cautioned, and measurement of fecal fats "did not differentiate between pancreatitis, carcinoma, or other causes of malabsorption."

A fourth test—endoscopic retrograde pancreatic cannulization—could not be adequately evaluated because of insufficient clinical experience, Dr. Manier explained. But since results of the test were normal in three patients with "obvious" disease, he suggests that additional tests be performed before concluding that the gland is normal.

On the positive side, Dr. Manier thinks the retrospective study demonstrated the value of the following:

- Abdominal gray scale ultrasound studies. Made in 23 patients, these provided the correct diagnosis for eight of 11 carcinomas, three out of three pseudocysts, four of six cases of acute pancreatitis, and one of three cases of pancreatic abscess.

This noninvasive technique represents a "major advance" but requires a high degree of skill in obtaining adequate films and in interpreting them accurately, Dr. Manier said. The chief problem is in differentiation of pancreatitis.

- Secretin test. It will differentiate pancreatis from carcinoma, the study indicated, and will also differentiate lesions of the head of the pancreas from those of the body and tail.

- Carcinoembryonic antigen assay. Although Dr. Manier emphasized that the CEA assay lacks specificity, he believes it may help identify potentially curable pancreatic carcinomas. Of 33 patients with carcinoma on whom the test was made, the three who had values in the normal range (below 2.5 ng/ml) have shown no evidence of metastasis and are still living.

- Enzyme tests (serum amylase, urine amylase, serum lipase). These were the most valuable of the tests in aiding diagnosis of pancreatitis, according to Dr. Manier's findings. Performance of more than one of them reduces the incidence of false-negative results, he said.

Medicine on Stamps

Earle Christian Grafton Page

Dr. Page (1880-1963) studied medicine at Sydney, Australia, and received his medical degree in 1901. He served his residency at Prince Albert Hospital and immediately began practicing in Grafton, New South Wales, soon becoming prominent as a general practitioner and surgeon. During WW-I he served oversens, then returned to his practice in Grafton in 1917. Elected Mayor of Grafton in 1918, he went on to become a member of the Federal Parliment and Prime Minister. A Foundation Fellow of the Royal Australasian College of Surgeons and an Honorary Fellow of the Royal College of Surgeons of England, he limited his practice to consultations after going into government service.

Text: Dr. Joseph Kler
Stamp: Minkus Publications, Inc., New York

Active Sarcoid Linked with Elevated ACE

Medical Tribune Report

NEW YORK—Additional evidence that patients with active sarcoidosis show elevated serum levels of the angiotensin-converting enzyme (ACE) was outlined here by Dr. Jack Lieberman, of the City of Hope Medical Center, Duarte, Calif.

Dr. Lieberman said his ongoing study now includes observations on 64 such patients and has demonstrated that assays of serum ACE activity can help clinicians judge the dosage of corticosteroids needed for effective control of sarcoidosis.

The enzyme is "most notable" for its presence within the capillary endothelium of the lungs, Dr. Lieberman explained, "where it acts to convert circulating angiotensin I into the active angiotensin II or to inactivate bradykinin."

Assays performed previously on sera from 172 healthy controls had indicated a mean ACE activity of 7.60 ± 2 units, the investigator reported to the Seventh International Conference on Sarcoidosis and Other Granulomatous Disorders.

In sharp contrast, the mean for the 64 patients with a confirmed diagnosis of active sarcoidosis was significantly higher—15.76 ± 7.4 units—and only five of the patients had normal serum ACE levels of less than 10 units per ml. Another five had values within the borderline range and the remaining 83% had values greater than 2 S.D. above the mean for healthy controls.

These levels differed markedly from those determined in 17 patients with resolved sarcoidosis, he noted. Only one patient in this group had an ACE value greater than 10 units per ml.

Dr. Lieberman emphasized that other patients with various lung diseases, including cystic fibrosis, tuberculosis, and lung cancer, were found to have lower levels of serum ACE than did healthy controls. Similarly, a number of nonpulmonary granulomatous diseases such as Hodgkin's, regional enteritis, and ulcerative colitis were not associated with elevated levels.

'Useful Procedure'

These findings suggest, he said, that detection of elevated serum ACE levels "can be a useful procedure" for confirming a diagnosis of active sarcoidosis.

The assay also provides a way of checking on the adequacy of corticosteroid dosage, according to Dr. Lieberman.

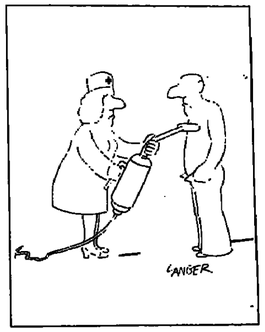
As part of the study, ACE levels were determined in 23 patients who were receiving daily doses of prednisone or its equivalent to control active sarcoidosis. Of the 11 taking 10 mg or less of prednisone, only six had normal serum ACE levels while levels were definitely elevated in three and borderline-elevated in two. However, of the remaining 12 patients who were receiving 15 mg or more daily, all had normal serum ACE levels.

A longitudinal investigation was made of the levels observed in some patients when prednisone dosage was reduced or increased, and showed that an ineffective dosage of corticosteroids can be recognized by persistence of elevated serum ACE levels or by the secondary rise of levels during reduction of steroid dosage.

One patient, for example, had an initial serum ACE level of 15.4 units before beginning a daily regimen of 40 mg. of prednisone. The serum ACE activity dropped to normal and remained so at a dosage of 10 mg but rose abruptly to 14.6 units after dosage had been reduced to 2.5 mg.—and the patient experienced a clinical relapse.

Since serum ACE was normal in patients who received therapeutic dosage of corticosteroids, or who had undergone spontaneous resolution of the disease, Dr. Lieberman concludes that elevated ACE levels "appeared to be associated with the active disease process and not to be a genetic predisposing factor."

Cosponsors of the symposium were the New York Academy of Sciences and the International Committee on Sarcoidosis.



Data Suggest MG Humorally Mediated Autoimmune Ill

Medical Tribune Report

BALTIMORE, MD.—A serum factor from human patients that on passive transfer reproduces many of the basic features of myasthenia gravis (MG) in laboratory animals has been demonstrated here for the first time by a research team from the department of neurology, Johns Hopkins University School of Medicine and Hospital. Although the nature of myasthenia-producing serum factor has not yet been elucidated, the investigators believe that their experiments may provide "the critical link" that establishes MG as "a humorally mediated autoimmune disease."

15 Mice Injected

Fifteen mice were injected daily, for 10 to 14 days, with ammonium sulfate-precipitated IgG and other protein fractions from the blood of six patients with typical MG.

The patients were being treated with pyridostigmine bromide, an anticholinesterase agent, but none had prior thymectomy or adrenal corticosteroid therapy.

Eleven control mice were given similar serum factors derived from the pooled blood of patients without MG.

The site fo the defect resulting in the abnormal weakness and muscle fatigue characteristic of MG has recently been defined as the acetylcholine receptors at the neuromuscular junction. Studies by the Johns Hopkins group have shown that in MG the number of available acetylcholine receptors is reduced by 80% below that of normal. Others have demonstrated a presumptive antibody in the serum of myasthenic patients capable of binding to acetylcholine receptors in vitro.

Mice receiving serum factors from the MG patients showed reduced amplitudes of miniature endplate potentials, and some showed typical decremental responses on repetitive stimulation of nerves associated with the left extensor digitorum longus and soleus muscles. Decreased response to nerve stimulation was reversible with intravenous neostigmine, an anticholinesterase agent. Sacrifice of the animals and examination of the neuromuscular junctions by the group's special technique revealed reduction of the acetylcholine receptor sites.

"Our study differs from the many previous attempts to transfer myasthenia gravis to animals over the past three decades in at least two important respects which contributed to the present positive results," reported Drs. Klaus V. Toyka, Daniel B. Drachman, Alan Pestronk, and Ing Kao. "We exposed the test animals to the serum factor for a relatively prolonged time, in contrast to the minutes or hours previously attempted. We used more sensitive electrophysical and radiometric methods to detect the myasthenic abnormalities rather than relying on clinical weakness or decremental responses, which are often absent.

". . . Whether the antibody that binds to ACh [acetylcholinesterase] receptor is itself the tranferable serum factor in myasthenic patients remains to be determined."

A Grateful Woman Patient Remembers . . .

Following the death of his father, Dr. G. S. Agadjanian, a general practitioner in New York City, his son Serge cleaned out his files. In them he found the moving letter below, written by a patient who first came to see Dr. Agadjanian about 1945. Efforts by MEDICAL TRIBUNE *to locate the writer failed. Therefore it is published anonymously.*

Dear Doctor:

It is nearing Christmas, and like anyone and everyone, I am addressing my greeting cards. Names and faces come tripping to me. Among these is one to whom I shall not want to send a card singing "Joyous Noel" with casual air. Nor shall I be content, as seasons before, to remember him with special thought and feeling tucked away in a simple greeting. No, this year, I want to remember him in a very special way.

It was on a warm summer evening several years ago. I knocked on the door of a busy doctor in busy New York. I remember how he chided me for having chosen a Sunday--of all days! He had every right. He did not know that I had awakened that morning wondering how I was to live another day. Nor did he know that I was terrified and in despair. However, the doctor lent patient ears to my little frightening story, and he proved to be extremely kind. I remember he gave me the privilege to visit him. And I did--every Saturday. How very much I looked forward to these visits. Somehow they made the days to follow tolerable. I remember how he would greet me at the door--always with a smile and a cheerful word of welcome-- regardless of how busy the day--and I know how very busy they always were. My doctor would talk to me in gentle tones. He would tell me amusing stories, and jokes, and sometimes he would scold me, really scold me. How well I recall! And he'd try with his wondrous humor to break a smile upon my frozen face--like trying to let the sunshine into a long shuttered room. Then he would sometimes philosophize and it would be a delight to listen. (I wish now I had been grown-up enough to have adopted this wisdom-filled philosophy on life.) I remember clinging to my good doctor and loving him for his kindness to me; of all those about me, he was the only one who understandingly gave me the strength to sustain my reason-- and yes, my life.

Even now, though a decade has passed, I still think of my doctor Agadjanian with the deepest affection and gratitude. It is natural for me to say "thank You" when one does me a kindness, but it is the phrase "I am grateful to you" that I want to utter when the kindness is of extraordinary nature, and what is more, unlimited reward or expectation thereof. In this, there is definitely the expression of godliness in man--at least to me.

So you see dear Doctor, why I wanted to remember you in this way, and why at a time so close to Christmas Day.

wine talk

By JOHN CHAMBERS
Author and Consultant to Morrell & Company, New York Wine Merchants

On Generic Types

"Taylor French Colombard! Taylor doesn't even *grow* French Colombard!"

The indignant speaker was an old medical friend who had moved upstate after spending his residency and post-residency years in New York City. He was right, of course, but he was also wrong. True, the Taylor Wine Company does not grow French Colombard, but the Company makes no claim that it does. The label reads *American French Colombard*, a designation which leaves point of origin unspecified. The wine is, in fact, a judicious mixture of California and New York State grapes: an attractive, slightly-sweet blend, nicely balancing the sugar of the California grape with the acidity of its Eastern cousin.

Major Categories

Domestic wines are divided into two major categories: the generics and the varietals. A generic is a generalized wine type, whereas a varietal is a wine type resulting from the primary use of a particular grape. Thus varietals will bear specific grape names (i.e., Cabernet Sauvignon, Zinfandel), and by law juice from the grape named must comprise 51% of the bottled wine. Generics will bear a generalized name (i.e., Burgundy, Chablis) and may be blended from whatever grapes the winemaker chooses to use.

Although there are general guidelines governing the use of these generic names, each company determines the specific character they will give to their generic blend. For example, while it is a general rule that generic Rhine wine will be sweeter than generic Chablis, there is no rule governing the relative dryness of generic Chablis. Hence Almaden chooses to make its Chablis dry, whereas Gallo makes it semi-sweet. The only way for the buyer to know is to taste, ask, or in a few instances, read the information printed on the wine label.

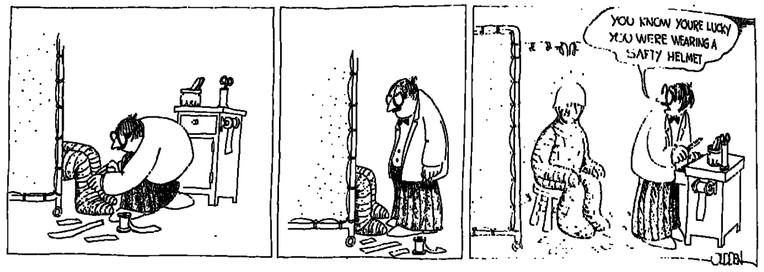
A sub-category of these generic wines are bottles which bear a proprietary name such as Masson's *Rubion*, Taylor's *Lake Country Red*, or Gallo's *Paisano*. Actually these wines are individual company generics which can be counted on to conform to type so long as they are popular and sell well.

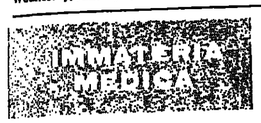
Geographic designations are easy, once one has the key. The most general term is *American* as used by Taylor with their French Colombard. All it means is that the wine comes from somewhere within the U.S.A. If the term *New York* had been used, then 75% of the wine would have had to have come from New York. Similarly if the term *Napa* is used on a California wine, 75% of the wine must come from the Napa Valley. The term *Estate Bottled* is even more specific, requiring that the grapes must be grown and the wine bottled on the property of the producer.

NEXT MONTH: Jug Wines—the Current Economy Scene.

Clinical Trials

By Oldden





Life on the Mississippi, Part II

From Indianapolis, Ind., Dr. Harold C. Halvorson writes:

"The power of the press is greater than I've ever imagined! In *Immateria Medica* (MT, Oct. 1) the Mississippi is placed along Council Bluffs, Ia. Which is the greater evidence of power?

1) To move Council Bluffs from the western to the eastern border of Iowa? Or

2) To move the Mississippi from eastern Iowa to western Iowa—and dislodge the Missouri River at the same time. (I trust mine is not the only awful [*sic*] letter on this.)"

That's Dr. Halvorson's *sic*.

Where Are We?

Well, now, we looked up Council Bluffs, the Mississippi and the Missouri in the *National Geographic Atlas*, and he is powerfully right. So we got on the horn, as Grandpa used to call the telephone, and read Dr. Halvorson's letter to our poor medical colleague who told his tale of traveling down the Mississippi in the pilothouse of a barge-pushing riverboat.

Said he: "It's that darn, lying pilot. I should have known not to trust him from the moment he told me Mark Twain's *Life on the Mississippi* was a pack of lies—and then later told me it was the best account. That should have been the tip-off.

Town of 'Beautiful Wimin'

"We passed this town on the river—and he nodded his head, spit in the spittoon and said, "That's Council Bluffs." Then he nodded at me, winked, and said, 'Beautiful wimin there, town's known for 'em.'

"I guess he just took me for an eastern dude—and he was right. I believed him. I should have looked for one of those riverside signs that reads like this: 'Passing friendly Council Bluffs— Courtesy of Kiwanis, Lions, Rotary Clubs.'

"Well, so he pulled my leg about Council Bluffs. If that column reached the riverboat crew they must have laughed all the way to N'Orleans.

"But what about all the other things he told me? Like pointing to a beautiful farm, white fenced, with many fine riding horses—maybe even thoroughbreds—and telling me, 'That's mah Daddy's place.'

'That's mah wife'

"And that place—a beautiful home by the river—where he blew the boat's whistle and a beautiful woman leaned out of a window and waved. He had told me she would—and he gave me the binoculars to see her better. Then he said, 'That's mah wife. She always waves. Except for passin' by, and blowin' my whistle, I never get to see her much.'

"I told that story to one of the crew and he just smiled.

"Well, that's life on the Mississippi. Or as the crew said on the boat: 'Just one dang fool after another.' What's got me worrying now is whether I really got off that boat in Memphis. It might have been Cape Girardeau."

Almost enough material here for a follow-up on Mark Twain's *Life on the Mississippi*. Could be called *Lies on the Mississippi*.

Motorcycle Ban Asked To Lower Road Deaths

Medical Tribune Report

SAN DIEGO—The most effective way to reduce the increasing number of motorcycle accidents on the nation's highways would be to ban them entirely from the road, according to Ben Kelley, Senior Vice President of the Insurance Institute for Highway Safety, Washington, D.C.

"The argument can be made, and in a public health context should be made, that until their design and operation can be modified so as to hold human losses to an acceptable minimum, motorcycles should no more be permitted on the road than should patent medicines with known lethal side effects be permitted in the family medicine cabinet," Mr. Kelley told a symposium at the 19th meeting of the American Association of Automotive Medicine.

No Necessity

Noting that the motorcycle is by no means a transportation necessity, Mr. Kelley pointed out that there are now five million motorcycles in operation on American roads, compared to 300,000 only 20 years ago. In addition, the death rate for motorcycle accidents is four times the auto death rate, with 90% of all motorcycle crashes resulting in injury compared to 10% in auto crashes.

Motorcycle education programs aimed at reducing the accident level have not worked, said Mr. Kelley, even though motorcycle drivers believe that their chances for having and surviving an accident are about what they are for an auto driver.

Aside from banning motorcycles entirely, Mr. Kelley proposed several alternatives for reducing the carnage, including limiting the vehicle's top speed and the minimum age of motorcycle owners, better helmet and vehicle design and improved test criteria.

To help meet those goals, he urged positive action on the part of public policy makers, parents and physicians "now tending the quadraplegics and paraplegics coming in increasing numbers from motorcycle crashes."